Patient Record of Disclosures - HIPAA

Patient: _____ **Patient Birth Date:** _____

My Phone Number Is: _____ Cell Home Work

My Second Number Is: _____ Cell Home Work

Yes No Leave message with detailed information

Yes No Leave call-back number ONLY

My Email Is: _____

Yes No Sign me up for Follow My Health Patient Portal

My Preferred Method of Contact: Patient Portal Phone US Mail

Bayside May Discuss My Detailed Medical Information With:

Name: _____

Relationship: _____ Birth Date: _____

Phone: _____

Is this same person your Emergency Contact as well? Yes No

If No, who: _____ Phone: _____

Lab Selection: (Please select 1)

- ❑ To have my labs drawn, I prefer to go to the Quest Labs
- ❑ To have my labs drawn, I prefer to go to a McLaren Draw Station / McLaren Hospital
- ❑ To have my labs drawn, I prefer to go to _____
- ❑ I prefer to have my labs drawn at Bayside, send my labs to: Quest or McLaren (Circle One)

The Health Insurance Portability and Accountability Act (HIPAA) privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication, or communication of PHI, by alternative means, such as sending correspondence to the individual's office, instead of the individual's home.

Acknowledgment: I have received, reviewed and understand the **Privacy Practices** and **Financial Policies** for Bayside Family & Sports Medicine

_____

Patient or Personal Representative Signature **Today's Date**

Relationship to Patient: (Please circle one) Self Spouse Child Parent/Legal Guardian

Office Staff Note: In the event the patient refuses to sign this acknowledgment, document the good faith effort to obtain the acknowledgment and the reason the acknowledgement was not obtained