

## Patient Authorization of Disclosure

In general, the 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 communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

**I wish to be contacted in the following manner (Check all that apply):**

### Telephone:

Home Telephone:

Leave message with call-back number only

O.K. to leave message with detailed information

Do not call me at home

Work Telephone:

Do not call me at work

Leave message with call-back number only

O.K. to leave message with detailed information

### Written Communication

O.K. to email (if applicable):

O.K. to mail to my home address:

O.K. to fax to my home fax:

OTHER: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Refused to sign

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In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at **Quality Choice Hearing Aid Center** may discuss your healthcare and scheduling needs as well as billing issues that may arise.

Only disclose information to myself

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_

Patient Signature: \_\_\_\_\_  
Date: \_\_\_\_\_