PROCARE INTERNAL MEDICINE ASSOCIATES

Patients (Please Print) Name: _____

In general, HIPAA privacy rules give 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 or that a communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home. Please review and answer the following carefully.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Check all that apply)

Home / Work Phone Number (Circle One)

_____Leave a detailed message on voicemail

_____Leave message with callback number only

Written Communication

_____Send mail to my home address

_____Please send mail to my work address at _____

_____Fax to the following # _____

_____Other (Please specify) _____

Is it OKAY to release information to anyone other than you? YES / NO. If YES, please list each person:

Name _____Relationship _____ Phone ( ) _____
Name _____Relationship _____ Phone ( )_____
Name _____Relationship _____ Phone ( ) _____

Please list any restriction for any of the named individuals:_____

_____

This is also to inform you that Protective Health Information (PHI) may be used and disclosed by the covered entity, which include physician offices, insurance companies, home health agencies, and entities necessary to carry out your treatment, payment, or health care operations. This allows us to provide/obtain information to covered entities for continued treatment. You have the right to request restrictions on uses and disclosures of PHI for treatment, payment, and health care operations purposes. The covered entity is not required to comply with the individual's request, but if the covered entity does agree to the request, the restriction is binding on the covered entity. You have the right to revoke this consent in writing, except to the extent that the covered entity has taken action in reliance on the consent. The terms of this consent are subject to change if new HIPAA (Health Insurance Portability and Accountability Act), rules are implemented. This is to verify that I have read and understand the above information by signing this statement and, I am giving PROCARE INTERNAL MEDICINE ASSOCIATES consent to release my personal information as described above.

Signature:_____Date:_____