

PATIENT RECORD OF DISCLOSURES

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 or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. I acknowledge that I have received *Advanced Dermatology and Skin Cancer Center's* Rights and Responsibilities policy and have been offered a copy of the entire HIPAA privacy notice. This notice is available at all times at *Advanced Dermatology and Skin Cancer Center*; I may request a copy of it at any time by contacting the Office Manager at 330-965-8760.

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

____ Home Telephone _____

____ Cell Telephone _____

____ OK to leave message with detailed info

____ OK to leave message with detailed info

____ Leave message with a call back only

____ Leave message with a call back only

____ Work Telephone _____

____ Written Communication _____

____ OK to leave message with detailed info

____ OK to mail to my home address

____ Leave message with a call back only

You may discuss my health information with:

NAME

RELATIONSHIP

PHONE

Patient Signature

Date

Printed Name

Date of Birth