



For All Patients

The HIPPA Privacy Act gives individuals the right to request a restriction on his or her doctor to disclose their health information to others. Communication will be made only if the patient requests it by the checking of one or more of the boxes below.

For my health information, I would like to be contacted at my

1. Home telephone number
2. Work telephone number

OR

3. Relative/friend telephone number:

Please give the name of the person you want us to contact:

- I would like to have detailed information left as a message on the phone

OR

- Please leave a message with a callback number with NO detailed information

PLEASE NOTE - Use and disclosure for personal information may be permitted without prior consent in case of emergency.

Patient Name _____

Signature of Patient _____