

Please date by appropriate year:

\_\_\_\_\_ 2005                      \_\_\_\_\_ 2006  
\_\_\_\_\_ 2007                      \_\_\_\_\_ 2008  
\_\_\_\_\_ 2009                      \_\_\_\_\_ 2010

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule give individuals the right to request uses and disclosures of the protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Is it okay for our office to call your home and leave a message about your next appointment?

\_\_\_ YES    \_\_\_ NO    If no, what # would you like to be contacted at \_\_\_\_\_

Home Telephone # \_\_\_\_\_  
\_\_\_ OK to leave a detailed message  
\_\_\_ Leave call back message ONLY

Cell Phone # \_\_\_\_\_  
\_\_\_ OK to leave a detailed message  
\_\_\_ Leave call back message ONLY

Work Telephone # \_\_\_\_\_  
\_\_\_ OK to leave a detailed message  
\_\_\_ Leave call back message ONLY

Written Communications  
\_\_\_ Mail to my home address  
\_\_\_ Mail to another address (Please specify)

Other: \_\_\_\_\_

Is there a relative or friend that you would like to have permission for our office to speak with in regards to your medical conditions or billing questions? If a person is not listed on this form and calls our office to discuss matters relating to your medical condition or billing we will not discuss this information with them.

I give permission \_\_\_\_\_ to speak with Dr. Robert J. Rosenstein or a  
(NAME)  
representative of Affiliated Podiatrist, Inc in reference to my medical information.

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

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birthdate

If this form is being completed by someone other than the patient:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient