

Internal Medicine of West Michigan Patient Record of Disclosure

In general, the HIPAA privacy rule gives the individuals the right to request a restriction on the use and disclosure of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication of their PHI or make a request of their PHI by alternative means, such as sending correspondence to the individual's office instead of individuals home. **Please fill out completely in order for our office to protect your health information.**

I wish to be contacted in the following manner:

Home Telephone: _____ **Cell Phone:** _____

- Leave message on voicemail / answering machine with detailed information.
- Leave message with call back number only.
- Leave detailed message with the following person only:

Work Telephone: _____

- Leave message on work voicemail / answering machine with detailed information.
- Leave message with call back number only.

Written Communication:

- Ok to mail written communication to my home address

DESIGNATION OF PERSONS INVOLVED IN CARE:

(Parents and Legal Guardians are assumed unless otherwise noted)

NAME	PHONE	RELATIONSHIP TO PATIENT	DATE OF BIRTH

RESTRICTIONS OF PERSONS INVOLVED IN CARE / COURT ORDERED

NAME OF RESTRICTED PERSON	SIGNATURE OF PARENT / LEGAL GUARDIAN

Patient Signature: _____ Date: _____

Print Name: _____ DOB: _____

Marital Status: (circle) M D W S