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 individual's home. **Completion of the entire form is required to protect your health information.**

*I wish to be contacted in the following manner:

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

*Select all that apply:

- ☐ 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: _____

*Select all that apply:

- ☐ 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

Preferred Communication:

- ☐ Phone Message
- ☐ Portal (electronic) Message
- ☐ Mail

*REQUIRED - DESIGNATION OF PERSONS INVOLVED IN CARE:

Provide Name(s) of all individuals with whom you allow us to share PHI with. (ie. Spouse, sibling, etc)

(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 all that apply) M D W S