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Patient Name:		**DOB:**		**Chart #:**	

Patient Information Authorization

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). Completion of this form tells us your preferences with regard to telephone messages and gives us information about individuals you have authorized to speak to us about your health care. Further authorization may be needed under more specific circumstances.

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

☐ Home Telephone:	____________	☐ O.K. to leave detailed message *	☐ Leave message with callback number only
☐ Work Telephone:	____________	☐ O.K. to leave detailed message *	☐ Leave message with callback number only
☐ Other Telephone:	____________	☐ O.K. to leave detailed message *	☐ Leave message with callback number only
* On answering machine or with any individual, other than yourself, who answers the telephone.			
Written Communication:	☐ O.K to email me at ___________________________________		
☐ O.K. to mail to my home	☐ O.K. to mail to my work address	☐ O.K. to fax to: __________________	

Other individuals I authorize to take messages or receive Protected Health Information are (check and list all that apply):

☐ Spouse Name								
	☐ Financial Records	☐ Psych Notes	Condition:	________	From:		To:	
	☐ Medical Records	Limited to Condition:		________	From:		To:	
	☐ Complete Medical Records				From:		To:	
☐ Relative (Name/Relationship to you)								
	☐ Financial Records	☐ Psych Notes	Condition:	________	From:		To:	
	☐ Medical Records	Limited to Condition:		________	From:		To:	
	☐ Complete Medical Records				From:		To:	
☐ Relative (Name/Relationship to you)								
	☐ Financial Records	☐ Psych Notes	Condition:	________	From:		To:	
	☐ Medical Records	Limited to Condition:		________	From:		To:	
	☐ Complete Medical Records				From:		To:	
☐ **Do not disclose Protected Health Information to anyone other than myself.**								

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign acknowledging receipt of this brochure.

Patient Signature: ____ Date: ______________________________

Witness: ____