COASTAL HEALTH
PRIMARY CARE

PATIENT RECORD OF DISCLOSURES

Patient Name: _____ Date:_____

Family Medical Centers has a policy of 100% compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the HIPAA Privacy Practices has been given to this patient to review and keep. The following method of operations will be used to insure privacy of your Protected Health Information (PHI).

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

1. Home telephone #: _____
__ Ok to leave a detailed message.
__ Leave message with call back number only.

2. Work telephone #: _____
__ Ok to leave a detailed message.
__ Leave message with call back number only.

3. Cell telephone #: _____
__ Ok to leave a detailed message.
__ Leave message with call back number only.

4. Written Communications:
__ OK to mail to my home.
__ OK to mail to work address.

Our office will provide information and records about your medical condition to other medical providers to whom you have been referred for treatment with this authorization.

Disclosure of PHI may be used without prior consent in an emergency!

If you wish to provide a designated individual(s) access to your medical records, please list the name(s) below. This includes family members that may want to discuss your condition with the physician and/or staff.

_____

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