

PATIENT CONSENT OF PROTECTED HEALTH INFORMATION (PHI) DISCLOSURES

In general, the **HIPPA PRIVACY RULE** gives individuals the right to request a restriction of uses and disclosures of their protected health information (**PHI**). The individual is also provided the right to request confidential communication.

This form is used as a guide to how we may contact you regarding appointments, test results and/or any other **PHI**.

Patient Name _____ Date of Birth _____

Please list the person(s) we may discuss your medical information with:

_____ Relationship _____ Phone # _____
Ok to discuss: () Appointments () Test Results () Billing Information

_____ Relationship _____ Phone # _____
Ok to discuss: () Appointments () Test Results () Billing Information

_____ Relationship _____ Phone # _____
Ok to discuss: () Appointments () Test Results () Billing Information

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

Home Telephone _____
Ok to leave message () Yes () No

Work Telephone _____
Ok to leave message () Yes () No

Cellular phone _____
Ok to leave message () Yes () No

Other _____
Ok to leave message () Yes () No

I, _____, have received a copy of Athena Urology Associates notice of Privacy Practices and have read and understood its contents.

Patient Signature Date _____