

# SOUTHEAST ORAL AND MAXILLOFACIAL SURGERY

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## PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

- |  |   |
|--|---|
| <input type="checkbox"/> Home Telephone _____                            | <input type="checkbox"/> Written Communication                  |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to mail to my home address        |
| <input type="checkbox"/> Leave message with call-back number only        | <input type="checkbox"/> O.K. to mail to my work/office address |
| <input type="checkbox"/> Work Telephone _____                            | <input type="checkbox"/> O.K. to fax to number indicated        |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> Other (Fax/Cell, etc.) _____           |
| <input type="checkbox"/> Leave message with call- back number only       | _____   |

I allow you to give my clinical information to or answer questions from (check all that applies):

- Spouse \_\_\_\_\_
- Parent \_\_\_\_\_
- Child \_\_\_\_\_
- Other (specify) \_\_\_\_\_
- None

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birth date