

In general, the HIPAA Privacy Act gives individuals the right to request restrictions 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 facsimile machine instead of the individual's home facsimile machine.

The office of Dr. Stephen Trammell has your permission to disclose medical information about yourself or minor patient to the following people:

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Should any of this information change, it is your responsibility to notify this office, in writing, as to the change to be made on the disclosure information.

**I HAVE PROVIDED THE OFFICE WITH NAMES AND THEIR RELATIONSHIPS WHOM DISCLOSURE CAN BE MADE ABOUT MEDICAL INFORMATION REGARDING THE ABOVE LISTED PATIENT. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY FOR CHANGES TO BE MADE TO THIS LIST.**

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

Home Telephone: \_\_\_\_\_  
\_\_\_ OK to leave message with detailed information  
\_\_\_ Leave message with call-back number only

Written Communication  
\_\_\_ OK to mail my home address  
\_\_\_ OK to fax to specified number I will provide

Work Telephone: \_\_\_\_\_  
\_\_\_ Leave message with call-back number only

Other \_\_\_\_\_

Cellular Telephone: \_\_\_\_\_  
\_\_\_ OK to leave message with detailed information  
\_\_\_ Leave message with call-back number only

\_\_\_\_\_  
Signature of Patient / Adult Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Birthdate (other than above patient)