Texas Oral Surgery Specialists

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# PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA 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 apply*):

☐ Home Telephone _____ (Phone Number)

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to number indicated

☐ Cellphone _____ (Cell Phone Number)

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Email Communication _____ (E-mail Address)

- ☐ O.K. to email detailed information

☐ Work Telephone _____ (Work Phone Number)

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other (Fax/Cell, etc.) _____

_____

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

- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Other (specify): _____
- ☐ None

By signing below I acknowledge that I agree to the contact information above AND I have had the opportunity to read, review and agree to the 1) Notice of Privacy Practices for Protected Health Information (HIPPA Agreement) which includes the Mutual Anti-defamation Agreement, 2) Patient's Rights Policy, and 3) Financial Policy

_____ Patient Signature

_____ Date

_____ Print Name

_____ Birth date

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