Kentuckiana Allergy, PSC

Patient Record of Disclosures

(Authorization to Discuss Health Information)

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by a preferred alternative method.

Patient Name: _____ **Date of Birth**: _____

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

☐ Work telephone: _____

__ Ok to leave message with detailed information

__ Leave message with call-back number only

☐ Cell phone: _____

__ Ok to leave message with detailed information

__ Leave message with call-back number only

☐ Text Message: _____

__ Ok to leave message with detailed information

__ Leave message with call-back number only

☐ Written Communication:

__ OK to mail to my home address

__ OK to fax to my work/office

__ OK to email me at: _____

Ok to leave message with detailed information: **circle one** – Yes No

Leave message with call-back number only: **circle one** – Yes No

"Preferred method of contact": _____

Who can we talk to about the patient's care? You may disclose my information to the following people (family, friends, caregivers, etc.)

Patient only_____

Name(s) of person (s) we can talk to:

1. _____ Phone #: _____
2. _____ Phone #: _____

Patient/Legal Guardian: _____/_____ Date: _____
Signature Print Name

Witness: _____/_____ Date: _____
Signature Print Name

To be completed if patient is under 18 years of age:

Who can bring your child in for <u>all</u> medical treatment including allergy injections?

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____
3. Name: _____ Relationship: _____

I authorize the above named individual(s) to bring my child in for medical treatment, for my child's medical history and plan of treatment to be discussed with them.

Parent/Legal Guardian (Circle one):

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

- Please note it is your responsibility to notify us of any changes. This authorization will remain in place unless we receive written documentation from you. Thank you.