Pacific Dermatology INSTITUTE

Pacific Plastic Surgery and LASER CENTER

Date: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA 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 is 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 _____ ☐ 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
- ◯ Work Telephone _____ ☐ OK to leave message with detailed information ☐ Leave message with call back number only
- ◯ Written Communications ☐ OK to mail to my home address ☐ OK to mail to my work/office address ☐ OK to fax:_____
  ☐ OK to email: _____
- ◯ Other _____

Please give those listed below access to my protected health information (PHI)

Name	Relationship	Contact number
Name	Relationship	Contact number

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to minimum necessary to accomplish the intended purposes. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures, information provided below, if completed properly, will constitute an adequate record.
NOTE: Uses and disclosures to TPO may be permitted without consent in emergency.

Please be advised that our Physicians are licensed and regulated by the Medical Board of California. Medical Boards' website is: www.mbc.ca.gov.

I, _____ understand that the Phsicians are licensed to practice in the State of California, and is regulated by the Medical Board of California.

I acknowledge that I have seen the HIPAA policy posted or requested to see a copy dated: _____

and I agree with the terms and conditions as stated.

(Signature of Patient or responsible party)	Printed Name	Date