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

**Patient Authorization of Disclosure**

In general, the HIPAA Privacy Rule gives you the right to request a restriction on uses and disclosures of your protected health information (PHI). You are also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to your office instead of your home. You may revoke or change this authorization at any time with a written request.

**It is acceptable to contact me in following manner (check all that apply):**

Home Telephone:

\_\_\_ OK to leave message with detailed information

\_\_\_ Leave message with call-back number only

Cell 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

\_\_\_ Do not call me at work

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Written Communication:

\_\_\_ OK to mail to my home address

\_\_\_ OK to fax to my home fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL:

\_\_\_ OK to send e-mail. Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Trinity Hearing Center does not share your email with others and will only send business-related emails, such as test results, appointment reminders and billing information.)*

**………………………………………………………………………………**

I give permission for Trinity Hearing Center to discuss my healthcare and scheduling needs, as well as billing issues that may arise, with:

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ PLEASE DO NOT DISCLOSE MY INFORMATION TO ANYONE OTHER THAN MYSELF

**………………………………………………………………………………**

I have been provided with a copy of Trinity Hearing Care’s Notice of Privacy Practices.

I wish to keep a copy of the Notice of Privacy Practices: \_\_\_\_YES \_\_\_\_NO

***PATIENT OR GUARDIAN SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***If guardian, indicate relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***