

Disclosure Authorization

As stipulated by the HIPAA privacy rule, patients have the right to control how and to whom their protected information is given. Please instruct as to how you would like the staff of Family Healthcare Associates to contact you.

Please contact me in the following manner (answer and check all that apply):

Home Telephone: _____

_____ May leave detailed message

_____ Leave message with call back number only

Work telephone: _____

_____ May leave detailed message

_____ Leave message with call back number only

Written Communication:

_____ Mail to my home address _____

_____ Mail to my work address _____

_____ Fax to this number: _____

In order to further protect your privacy, we will only disclose your health care information to the family members (or others close to you) if you authorize us to do so. If you permit us to share your medication information with others on a regular basis, please list their names below.

Name	Relationship	Phone number
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This authorization is effective from _____ until _____.
(effective date) (expiration date)

Patient Name:

D.O.B.:

Signature of patient:

Date: _____

Description of personal representative authority:
