



PATIENT RECORD OF DISCLOSURES

Name of Patient: _____

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 _____
 - O.K to leave message with detailed information
 - Leave message with call-back number only
- Work Telephone _____
 - 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 this number
- Other _____

Patient Signature Date

Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These 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 for TPO may be permitted without prior consent in an emergency

I, _____, hereby authorize *Nevada Fertility C.A.R.E.S* to disclose my protected healthcare information to _____. I am fully aware that once the information is released to the above named person, Nevada Fertility C.A.R.E.S will not be held liable for any misuse of the information given. (EXAMPLE SPOUSE'S NAME, CHILD, RELATIVE, ETC.)

Acknowledgement of Receipt of Privacy Practices

I, _____ have received a copy of **Nevada Fertility C.A.R.E.S.** Notice of Privacy Practices with an effective date of April 14, 2003 effective date of Notice of Privacy Practices.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____