Tyler Obstetrics & Gynecology, LLP

PATIENT RECORD OF DISCLOSURE

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") gives individuals certain rights to privacy regarding protected health information (PHI). The individual is also granted the right to request confidential communication, or that communication be made by alternative means.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: (Number the selections below in order of your preference)

_____ By my **home** telephone. My number is: _____

_____ It is ok to leave me a message with detailed information.

_____ It is NOT ok to leave me a message with detailed information.

_____ By my **cell phone**. My number is: _____

_____ It is ok to leave me a message with detailed information.

_____ It is NOT ok to leave me a message with detailed information.

_____ It is ok to contact me at **work**. My number is: _____

_____ It is ok to leave me a message at work with detailed information.

_____ It is NOT ok to leave me a message at work with detailed information.

_____ It is ok to leave a callback number ONLY at my work number.

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (fill in all that apply)

_____ My spouse - Name: _____ DOB: _____ Phone: _____

_____ My parent - Name: _____ DOB: _____ Phone: _____

_____ Other: _____ DOB: _____ Phone: _____

_____ No one other than myself

Signature of Patient: _____ Date: _____

Printed Name: _____

Signature of Parent or Legal Guardian: _____ Date: _____
(If patient is under the age of 18 or unable to authorize consent)

Printed Name: _____