ESSEX DERMATOLOGY

HIPAA Disclosure Notice & Authorization(s)

Patient Name: _____ **DOB**:_____

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.

The Privacy Rule 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. *Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.*

I wish to be contacted in the following manner (check all that apply)

□ **Home phone** □**Cell phone** □**Other phone** _____
□Ok to leave detailed message
□ Leave message with call back number only

Written communication
□Ok to mail my home address

Please indicate anyone other than yourself that is authorized to receive information about your care.

Name: _____ Relation: _____ Phone #: _____	**Description of information to be released** □ Financial □ Medical

- I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- *I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.* **This authorization shall remain in effect until revoked by the patient.**

Signature of patient or personal representative: _____ Date: _____