Spectrum Pain Clinics

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of personal health information. (PHI) The individual is also provided the right to request confidential communications or that if communications 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
- ☐ 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 _____

I hereby give Spectrum Pain Clinics staff permission to discuss my medical care, lab results, billing, and medication, with the following individuals:

- ☐ Spouse _____
- ☐ Son/Daughter _____
- ☐ Other _____

ACKNOWLEDGEMENT:

I acknowledge that i have received a copy or reviewed the Privacy Practices for Spectrum Pain Clinics.

If at any time you would like this permission revoked, you will need to contact Spectrum Pain Clinics.

Patient Signature/ Representative _____ Date _____

Print Name/Relationship _____ Birth Date _____