**HOW OUR OFFICE MAY CONTACT YOU**

*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.*

*This office will generally contact patients by written communication or phone calls. We will send letters or call the number that you have provided us on your Registration Form.*

Home Telephone

[ ] Okay to leave message with detailed information.

[ ] Leave message with callback number only.

Cellular Telephone

[ ] Okay to leave message with detailed information.

[ ] Leave message with callback number only.

Work Telephone

[ ] Okay to leave message with detailed information.

[ ] Leave message with callback number only.

[ ] Okay to FAX to ( )

Written Communication

[ ] Okay to mail to my home address

[ ] Please mail to another address:

*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 for use or disclosures made pursuant to an authorization requested by the individual*.

**Record of Disclosures of Protected Health Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the office of Horizon Cardiology to contact the following person(s) regarding my medical information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Relationship Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Relationship Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature/ Date of Birth Date