

UB Oral & Maxillofacial Surgery, Inc.

PATIENT DISCLOSURE INSTRUCTIONS

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*):

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone _____ | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to mail to my home address |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> O.K. to mail to my work/office address |
| | <input type="checkbox"/> O.K. to fax to number indicated |
| <input type="checkbox"/> Work Telephone _____ | <input type="checkbox"/> Other (Fax/Cell, etc.) _____ |
| <input type="checkbox"/> O.K. to leave message with detailed information | _____ |
| <input type="checkbox"/> Leave message with call-back number only | |

I allow you to give my clinical information to or answer questions from (*check all that apply*):

- Spouse
- Parent
- Child
- Other (specify): _____
- None

Patient Signature

Date

Print Name

Birth date