

General & Vascular Surgeons, P.C.
PATIENT AUTHORIZATION OF DISCLOSURE

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 patient may revoke or change this authorization at any time with a written request. The patient may request contact in an alternate manner. General & Vascular Surgeons, PC will honor this request if possible.**

Patient's Name: _____
I wish to be contacted in the following manner.

Section A: Please complete this section. **CHECK ALL THAT APPLY.**

This number is my preferred contact number: _____
(Please check as many options below as apply:)

- This number is my home phone
- This number is my cell phone
- This number is my work number
- OK to leave message with detailed information
- Leave message with call-back number only
- I DO NOT HAVE A PHONE.** You may leave a message for me at the following number:

- _____
- This number belongs to: _____
- He/She is my (relationship to patient): _____

- IF YOU DO NOT HAVE A PHONE NUMBER PLEASE COMPLETE:**
 - OK to leave a message regarding the following. (Please check all that apply):
 - An Appointment
 - Testing or Surgery
 - Billing Information which may include requests for insurance information or payment
 - Leave message with call back number only

Patient's Signature: _____ **Date:** _____

Patient Refused to sign, initialed by: _____ (GVS EMPLOYEE USE ONLY)

Section B: Please complete #1 or #2 below. In a further effort to protect your health information and the confidentiality of your healthcare, please indicate below to whom, if anyone, we may talk to regarding your personal health information. This may include medical and/or financial information.

1. **Only disclose information to myself. By checking this option, I understand that GVS will not speak with any other person(s) regarding my health information, including family or friends.**

2. **GVS may speak with the following person(s) regarding my health information:**

| <u>Name</u> | <u>Relationship</u> | <u>Phone Number(s)</u> |
|-------------|---------------------|------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Patient's or Legal Representative's Signature _____ **Date** _____

If Legal Representative, Name & Relationship: _____