

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.***

Patient Name: _____

I wish to be contacted in the following manner (CHECK ALL THAT APPLY).
PLEASE LET US KNOW THE PREFERRED NUMBER TO CONTACT YOU.

Home Telephone: _____

- O.K. to leave message with detailed information
- Leave message with call-back number only
- THIS IS MY PREFERRED CONTACT NUMBER

Work Telephone: _____

- O.K. to leave message with detailed information
- Leave message with call-back number only
- Do not call me at work
- THIS IS MY PREFERRED CONTACT NUMBER

Cell Telephone: _____

- O.K. to leave message with detailed information
- Leave message with call-back number only
- Do not call me on my cell phone
- THIS IS MY PREFERRED CONTACT NUMBER

Written Communication ****GVS does not currently communicate with patients via email due to security concerns****

- O.K. to mail to my home address
- O.K. to fax to my home fax: _____

Patient Signature: _____ Date: _____

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

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In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the physicians and staff at General & Vascular Surgeons, P.C. (GVS) may discuss your healthcare and scheduling needs as well as billing issues that may arise.

- Only disclose information to myself. **By checking this option, I understand that GVS will not be able to speak with any other person(s) regarding myself.**

Name _____ Relationship _____ Phone Number(s) _____

Patient Signature _____ Date _____