Coastal Carolina Internal Medicine, PA

PATIENT RECORD OF DISCLOSURES

Patient's Name: ____________________________________ Date of Birth: ____________________

I understand that my health information is private and confidential. I understand that Coastal Carolina Internal Medicine, PA works very hard to protect their patient's privacy and preserve the confidentiality of the patient's personal health information (PHI)

Under the terms of this consent, I ask Coastal Carolina Internal Medicine, PA to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Coastal Carolina Internal Medicine, PA does not have to agree to my request. If Coastal Carolina internal Medicine, PA does agree to my request, I understand that Coastal Carolina Internal Medicine, PA would follow the agreed limits.

I may cancel this consent in writing at any time by doing one for the following:

1) Signing and dating a form provided by Coastal Carolina Internal Medicine, PA revoking my consent; or,
2) Writing, signing, and dating a letter to Coastal Carolina Internal Medicine, PA indicating that I want to revoke my consent to authorize the use and disclosure of my PHI for treatment, payment and health care operations.

   If I revoke this consent, Coastal Carolina Internal Medicine, PA does not have to provide any further health care services to me.

My signature below means that I agree to allow Coastal Carolina Internal Medicine, PA to use and disclose my PHI to carry out treatment, payment and health care operations.

Furthermore, I understand that the privacy rule gives me the right to request restriction on uses and disclosures of my PHI as well as to request confidential communications of my PHI be made by alternative means. I wish to be contacted in the following manner (check all that apply, indicate individual's name if applicable):

Home Phone ____________________ O.K to leave a message with detailed information __
Leave a message with call-back number only __

Work Phone ____________________ O.K to leave a message with detailed information __
Leave a message with call-back number only __

Indicate Name and relationship of Person/s authorized to have access to your PHI:

Name ______________________________ ____Relationship __________________________________

Name ___________________________________Relationship __________________________________

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 to use or disclosure made pursuant to an authorization requested by the individual.

A record of disclosures will be kept in your medical records.

NOTE: Uses and disclosures for PHI may be permitted without prior consent in an emergency situation.

_________________________ Patient Name

___________________________ Patient Signature

________________________ Date of Birth