Wayne Memorial Community Health Centers

A Wayne Memorial Health System Affiliate

PATIENT RECORD OF DISCLOSURES

In general, *the* HIPAA PRIVACY RULE permits WMCHC to communicate with our patients regarding their health care. This includes communicating with our patients at their homes, whether through the mail or by phone or in some other manner. In addition, the Rule does not prohibit WMCHC from leaving messages for patients on their answering machines. Please select your preferences below. WMCHC recognizes our patients' right to request a restriction on uses and disclosures of their protected health information (PHI). Patients can 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. Please note any preferences below.

In an effort to protect our patients' privacy, generally we will not disclose protected health information to anyone other than the patient if over the age of 18, unless express permission is granted to another person through the patient permission section on this form below.

PATIENT NAME: _____ **Date of Birth:** _____

- ☐ **Home Telephone** _____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave a message with a call back number only
- ☐ **Cell Phone**_____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave a message with a call back number only
- ☐ **Work Telephone** _____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave a message with a call back number only
- ☐ **Written Communication**
  - ☐ OK to mail to my home address
  - ☐ OK to send email to my email address
- ☐ ***Other*** _____

Please indicate the BEST WAY TO REACH you:

_____

CELL/HOME/WORK PHONE # or EMAIL

(Write in please and circle one)

PLEASE PROVIDE YOUR EMAIL ADDRESS:

_____

EMAIL ADDRESS

Alternate Contact: *Person to whom we may disclose your health information:* ☐ check box if **NONE**

Print Person/Alternate Contact's Name:_____ Relationship: _____
Best number to reach this person: _____

Print Person/Alternate Contact's Name:_____ Relationship: _____
Best number to reach this person: _____

Print Person/Alternate Contact's Name:_____ Relationship: _____
Best number to reach this person: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I acknowledge that I have received the Notice of Privacy Practices for Wayne Memorial Community Health Centers. I have been given an opportunity to ask any questions regarding the privacy notice that I may have at this time, and agree to have my health information disclosed (as necessary) as indicated above. I am also aware that I may contact the privacy officer at 570-251-6676 if I have any further questions.

Patient Signature: _____ Date _____

Parent/Guardians Signature: _____ Date _____

PRINT NAME: _____

Date Reviewed/Signature:_____ ***Date Reviewed/Signature***:_____

Date Reviewed/Signature:_____ ***Date Reviewed/Signature***:_____