Disclosure Agreement Form

In order to provide the best care possible, we may call the patient's home with information regarding appointment changes, test results, and treatment plans. Please complete the following so that we can ensure that all communication regarding your protected health information remains confidential.

Phone: You can contact me by phone at _____

Leave messages on answering machine: ____ Yes ____ No

Leave message with any other person: ____ Yes ____ No

If yes, please specify who is authorized to accept information regarding your treatment:

_____
(Name) (Relationship to patient)

_____
(Name) (Relationship to patient)

_____
(Name) (Relationship to patient)

Last 4 Digits of Patient's SSN: _____

Please Note: Individuals receiving information regarding your treatment will be required to provide the last four digits of your social security number in order to verify authorization.

Mail: Contact me at the following address: _____

_____

FAX: ____ Please do not contact me by FAX

____ Please contact me by FAX at _____

Other Requests for Confidential Communications: _____

_____

_____

Name: _____

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____