Patient Record of Disclosures

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 individuals is also provided the right to 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.

I wish to be contacted in the following manner (check all that apply):

_____ **Home Telephone**

____ OK to leave message with detailed information

____ Leave message with call-back number only

_____ **Written Communication**

_____ OK to mail to my home address

_____ OK to mail to my work/office address

_____ **Work Telephone**

____ OK to leave message with detailed information

____ Leave message with call-back number only

_____ **Cell Telephone**

____ OK to leave message with detailed information

____ Leave message with call-back number only

_____ **Email Communication**

_____ Ok to email to this email address: _____

Approve Telehealth Visits

Preferred Email for Telehealth communication: _____

As a patient or guardian of a patient of Psychiatric Associates, I acknowledge by signing this document that if I choose to communicate with Psychiatric Associates in any capacity via email there is a risk my private health information could be violated. I accept this risk and agree to hold Psychiatric Associates blameless in the event this would occur. I also acknowledge and am aware of the fact that Psychiatric Associates and its providers will continue to do everything in their power to keep my confidential information safe, including maintaining a secure email server on the side of the practice. Risk of confidential information being unsecured may come on the end of my own email server and I am aware of this and accept it by choosing to communicate via email with my provider. My signature below serves as indefinite consent to this policy unless I revoke it in writing.

Patient Name: _____ Patient D.O.B. _____

Patient Signature: _____ Date: _____