

CARDIOLOGY ASSOCIATES OF SAVANNAH, LLC

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information. (PHI)

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 callback number only

- Work Number _____
 - OK to leave message with detailed information
 - Leave message with callback number only

- Written Communication
 - OK to mail to my home address (address) _____
 - OK to mail to my work/office (address) _____
 - OK to fax to this telephone number _____

You may leave a message with, discuss my treatment, appointment, or other scheduling that may occur or give other information as necessary with the following family, friends, or personal representatives. I understand that Cardiology Associates of Savannah will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers.

PLEASE PRINT

1. _____
2. _____
3. _____
4. _____

Patient's Signature

Print Name

Date of Birth

Date _____