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 individual 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 _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate

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 uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

STEVEN M. SOCKIN, M.D., F.A.C.A.A.I., F.A.A.A.A.I.
ALLERGY AND ASTHMA CARE
500C NEW HEMPSTEAD ROAD
NEW CITY, NY 10956

DIPLOMATE AMERICAN BOARD OF ALLERGY & IMMUNOLOGY
FELLOW, AMERICAN COLLEGE OF ALLERGY & IMMUNOLOGY
FELLOW, AMERICAN ACADEMY OF ALLERGY & IMMUNOLOGY

TELEPHONE: (845) 362-3222
FAX: (845) 362-2508

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

By signing below I acknowledge that I have been provided a copy of the Notice of Privacy Practices

You may discuss results and treatment of my conditions with:

SPOUSE YES NO

CHILDREN YES NO

OTHERS YES NO Specify_____

_____
Signature of Patient or Personal Representative

_____ _____
Print Name of Patient or Personal Representative Relation to Patient

_____
Date

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I have received a copy of this notice

_____
Signature

_____
Print Name

_____
Date

I make the following special request for confidential communications:

_____
_____
_____
_____

_____ _____
Signature Date