HIPAA Confidential Communications Form

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_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Work 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 my work/office address
  - ☐ OK to fax to number: _____

☐ Other _____

Permission to Disclose Information Form

☐ I allow Columbus Hospital (inclusive of Columbus Medical Clinic and Four Oaks Medical Clinic) to discuss my medical information with:

_____relationship _____

_____relationship _____

_____relationship _____

☐ I request that my medical information not be shared with anyone other than another medical provider or a pharmacy.

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth

Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy.