DARYL R. RHEUARK, M.D., M.S., F.A.C.S.

Disclosure Authorization

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 can also request that confidential communication, whether telephone communication or correspondence, be directed to an alternate site, such as the individual's office.

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

Cellular 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: ____

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☐ O.K. to fax to: (________) ________________________________

Other: ____

I hereby consent to the release of Protected Health Information to the following individual(s) (Example: Family member, friend, etc.). I understand this authorization will be in effect until which time it is revoked.

____ Names/Relationship (please print)

____ Names/Relationship (please print)

____ Names/Relationship (please print)

____ ____________________

Patient or Guardian Signature Date

____ ____________________

Please Print Patient Name Date of Birth

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