

JACK A. DAVIDSON, D.D.S., M.D., PLLC

Plastic, Maxillofacial & Reconstructive Surgery

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). Some examples of PHI: appointment confirmation calls, review/discussion of pre & post operative patient instructions, follow-up phone correspondence, etc. 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 applies*):

- 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 number indicated
- Other (Fax/Cell, etc.) _____

I allow my clinical information to be discussed with (*check all that applies*):

- Spouse
- Parent
- Child
- Other (specify): _____
- None

Patient Signature Date

Print Name Birth date

*******OPTIONAL:** (*you will only be required to acknowledge the information below if you are requesting electronic mailing of confidential patient information*)

ELECTRONIC MAIL COMMUNICATION:

I authorize Jack A. Davidson, D.D.S., M.D., PLLC to electronically mail my confidential patient information to: _____.

I understand that for the most part, electronic mailing is a safe practice; however, confidential information can be jeopardized by unauthorized external entities at any time. I will not hold **Jack A. Davidson, D.D.S., M.D., PLLC**, its employees nor its associates responsible for any unauthorized activity incurred by unauthorized entities.

Patient Signature Date