EFFINGHAM HEALTH SYSTEM®

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of protected health information. Protected Health Information (PHI) is the use or disclosure about your medical treatment, payment or healthcare operations

PLEASE PRINT BELOW THE PERSON(S) TO WHOM WE MAY DISCUSS YOUR PHI AND RELEASE INFORMATION TO:

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

I wish to be contacted in the following manner (check all that apply)

_____ Home Telephone _____

_____ Cell Phone Number _____

_____Email_____

_____Mail_____

You may leave a message with, discuss my treatment, appointments, release information, or other scheduling that may occur or give information as necessary with the above family, friend or personal representatives. I understand that Effingham Health System 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 for continuity of care.

_____	_____	_____
Patient's Signature and Date	**Patient's Printed Name**	**Date of Birth**