



DIVISION OF

VASCULAR AND ENDOVASCULAR SURGERY

Patient Name: _____ DOB _____
(Please Print)

PATIENT DISCLOSURES/COMMUNICATIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information.

_____ Authorization to speak with others concerning my personal health information.

_____ **Family**

If so, whom _____ Password _____

_____ **Friends**

If so, whom _____ Password _____

_____ **Others**

If so, whom _____ Password _____

_____ Authorization to leave my personal health information on my answering machine

If so, number _____

Please specify anyone who you **DO NOT** wish us to disclose information:

Signature

Date