GEORGE R. GOTTLIEB, M.D., P.C.
ASTHMA AND DISEASES OF ALLERGY

PATIENT NAME _____ DOB_____

PHONE # _____

WORK # _____

CELL # _____

ADDRESS

_____

_____

HIPPA POLICY

In General, the HIPAA Privacy Rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of 'PHI' (Protected Health Information) be made by alternative means, such as sending information to the individual's office instead of their home.

You can specify how to communicate your Protected Health Information (PHI).

(CHECK and ENTER INFORMATION to all that apply):

HOME:

☐ OKAY TO REACH ME BY CELL PHONE NUMBER: _____, TEXT: _____

☐ OKAY TO LEAVE VOICE MAIL MESSAGE WITH DETAILS _____

☐ OR ONLY LEAVE VOICE MAIL MESSAGE TO CALL BACK

WORK :

☐ OKAY TO LEAVE VOICE MAIL MESSAGE WITH DETAILS _____

☐ OR ONLY LEAVE VOICE MAIL MESSAGE TO CALL BACK

WRITTEN COMMUNICATION:

☐ MY HOME _____

☐ MY WORK _____

☐ OR OTHER ADDRESS: _____

I GIVE DR. GOTTLIEB AND STAFF PERMISSION TO USE AND DISCLOSE 'PHI' AS NECESSARY TO OTHER PHYSICIANS I AM SEEING OR TO INSURANCE COMPANIES.

BY SIGNING THIS FORM, I UNDERSTAND THAT THE PRIVACY PRACTICES OF THE OFFICE HAVE BEEN DISCLOSED TO ME. THIS INFORMATION WILL STAY ON RECORD FOR 6-YEARS.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

SIGNED: _____ **DATE:** _____