Collin County Pulmonary Associates
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PATIENT RECORD OF DISCLOSURES

In general, HIPPA privacy rules give individuals the right to request a restriction on uses and disclosures of their medical records and protected health information (PHI). 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 individuals home.

For your information and before you sign this disclosure, please be advised that Collin County Pulmonary Associates in the past, present and future:

- Has always required documented permission of a patient or their legal representative before releasing medical records to anyone
- Has always faxed medical records to patients only if we are first sure that the patient has direct personal control of the receiving fax machine at the time we transmit the information
- Has always called the home telephone number to contact you, unless you have specifically indicated otherwise, or we are responding back to your call from some other number
- Has always refused to release your medical or personal patient information to pharmacies and medical suppliers for their marketing or solicitation

There are NO Restrictions on disclosure of my PHI except as indicated below:

- ☐ Never leave a phone message at my HOME TELEPHONE number
- ☐ Never leave a phone message at my WORK TELEPHONE number
- ☐ Never correspond with me by e-mail
- ☐ Never mail anything to my home address
- ☐ Other_____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer
- I may refuse to sign this authorization and that you will not condition my treatment on me providing this authorization

I understand that it is my personal responsibility to keep my home phone number, home address, work address, and email address up to date and accurate for confidential communications of PHI. The current information you have on file today is correct and should be used unless or until I contact you with any changes.

This authorization shall remain in effect from the date signed below unless or until_____.

Patient Name: _____Signature: _____

Relationship if other than patient: _____ Date: _____