Dr. Kuthiala Allergy & Asthma

PATIENT RECORD OF DISCLOSURE

Dr. Kuthiala has a policy of 100% compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of HIPAA Privacy Practices has been given to you to review and keep. The following method of operations will be used to insure privacy of your Protected Health Information (PHI).

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

1. **Home Telephone #: _____**
   - □ Ok to leave a detailed message.
   - □ Leave message with call back number only.

2. **Work Telephone #: _____**
   - □ Ok to leave detailed message.
   - □ Leave message with call back number only.

3. **Cell Telephone #: _____**
   - □ Ok to leave detailed message.
   - □ Leave message with call back number only.

4. **Written Communication:**
   - □ OK to mail to my home address.
   - □ OK to mail to my work address.

Disclosure of PHI may be used without prior consent ONLY IN AN EMERGENCY!

If you wish to provide a designated individual(s) access to your medical records, please list the names(s) below. This includes family members that may want to discuss your condition with the physician and/ or staff.

_____
_____
_____

Patient Signature_____

Date_____