SHORE HEALTH WELLNESS CENTER

Release of Medical Information

In general, the HIPAA privacy rule gives individuals the right to require a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided to the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Our practice will accommodate **reasonable** requests. We may also condition this accommodation by asking you how payment will be handled. You do not have to give us a reason for your request. **Any requests in addition to those listed below must be made in writing to our Office Manager.**

You also have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosures of your PHI to only certain individuals involved in your care or the payment of your care, such as family members and friends. **We are not required to agree to your request; however**, if we do agree we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.

In order to request a restriction in our use or disclosure of your PHI in addition to those listed below, you must make your request in writing to our Office Manager. Your request must describe in a clear and concise fashion:

***The information you wish restricted**
***Whether you are requesting to limit our practice's use, disclosure or both**
***To whom you want the limits to apply**

Shore Health Wellness Center, its providers and staff are authorized to share information and provide copies of my entire medical record; *excluding psychotherapy notes;* but including all written and oral reports, substantive evaluation of progress, history, diagnosis, prognosis, course of treatment, reports and attendance and compliance with respect to all care or treatment, including confidential HIV and AIDS related information, to my insurance companies, doctors, treating facilities, and my employer in the case of disability paperwork, return to work paperwork and/or Worker's Compensation and the following persons:

INITIAL ALL THAT APPLY

_____Spouse _____Parents, if over 18 _____Power of Attorney _____Patient's Children

Other (Specify)_____

THIS ASSIGNMENT REMAINS IN EFFECT UNTIL REVOLKED BY ME IN WRITING.

_____ _____

SIGNATURE OF PATIENT, GUARDIAN OR POWER OF ATTORNEY DATE

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER-INITIAL ALL THAT APPLY

_____Home Phone
_____OK to leave message with detailed info
_____Leave message with call-back number only

_____Cell Phone
_____OK to leave message with detailed info
_____Leave message with call-back number only

_____Work Phone
_____OK to leave message with detailed info
_____Leave message with call back-number only

_____Mail to Home _____Mail to Work
_____Fax _____Email _____Patient Portal
_____Other_____

_____ _____ _____

PATIENT SIGNATURE PRINT NAME DATE