Reston Pediatrics

HIPAA CONTACT FORM

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

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

- ☐ Home Telephone No.:_____
- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Work Telephone No.:_____
- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Cellphone No.:_____
- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Written communication
- ☐ Mail to my home address
- ☐ Mail to my work/office address
- ☐ Fax to this number:_____
- ☐ Emailed* to:_____

*****For email communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication as selected.

- ☐ Other_____
  _____
  _____

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Entire Record ☐ Psychotherapy Notes ☐ Office Visit Notes ☐ Diagnostic Studies ☐ Specific Conditions (describe)

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised July 2017