

**Rheumatology Associates of Central Florida, PA
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Health Insurance Portability and Accountability Act (HIPAA)

PLEASE PRINT CLEARLY

PATIENT NAME: _____

PARENT OR SPOUSE NAME: _____

PREFERRED PHONE # _____

ADDRESS: _____

EMAIL ADDRESS: _____

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.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

HOME TELEPHONE:

OK TO LEAVE MESSAGE WITH DETAILS
LEAVE MESSAGE WITH CALL BACK NUMBER
AUTHORIZED PERSON TO SPEAK WITH _____

CELL PHONE:

OK TO LEAVE MESSAGE WITH DETAILS
LEAVE MESSAGE WITH CALL BACK NUMBER

WRITTEN COMMUNICATION:

OK TO MAIL TO MY HOME

EMAIL:

OK TO SEND EMAIL WITH DETAILS

WORK TELEPHONE:

OK TO LEAVE MESSAGE WITH DETAILS
LEAVE MESSAGE WITH CALL BACK NUMBER

I GIVE RHEUMATOLOGY ASSOCIATES OF CENTRAL FLORIDA, PA, PERMISSION TO USE AND DISCLOSE PHI NECESSARY TO CARRY OUT TREATMENT OR PAYMENT. BY SIGNING THIS FORM, I UNDERSTAND THAT THE PRIVACY PRACTICES OF THE OFFICE HAVE BEEN DISCLOSED TO ME.

SIGNATURE *X* _____ DATE _____