Patient Name ______________________________
Chart # ___________________________________

Raleigh Adult Medicine, P. A.

Request for Limitations and Restrictions of Protected Health Information

How would you prefer that we communicate your protected health information (PHI) with you if you cannot be reached directly? Your PHI includes general health information, laboratory tests, diagnostic test results, appointment reminders, and patient demographics/billing information.

Please answer the following questions by marking YES or NO.

1. Is it ok to leave messages on your home answering machine? YES ___ NO ___
2. Is it ok to leave messages on your work voice mail? YES ___ NO ___
3. Do you want us to contact you by cell phone and/or leave a message on your cell phone voice mail? If YES please provide number _________________ YES ___ NO ___
4. Is it ok to leave messages with your spouse or domestic partner? YES ___ NO ___
5. Is it ok to leave messages with your son/daughter over 18 years of age? If YES please provide name of child or children ______________________ YES ___ NO ___
6. Is it ok to mail protected health information to your home? YES ___ NO ___

Please list any exception(s) to the above ____
____

Sensitive information such as HIV results, STD results, abnormal results and diagnoses will not be left as messages. Information regarding sexually transmitted diseases will only be released to the patient.

The information discussed between you and your healthcare provider is strictly confidential. Please indicate below any individual(s) allowed to accompany you into the exam room and/or receive your medical information.

____ ____

I have reviewed and I understand this form. Please sign below.

_______________________________________ Date ___________________________
Patient

or _____________________________________ Date ___________________________
Patient's Representative

_______________________________________ Date ___________________________
Nurse