Digestive Disease Consultants
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Alan F. Shikoh, M.D.
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PATIENT PRIVACY POLICY

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication PHI be made by alternative means, such as sending correspondence to the individual's office instead of individual's home.

Patient Name_____

Home Telephone_____
□ O.K. to leave message with detailed information
□ Leave message with call-back number only

Written Communication
□ O.K. to mail to my home address
□ O.K. to mail to my work/office

□ O.K. to leave message with detailed information at Work Telephone_____ □ Leave message with call-back number only

Authorization to release Protected Health Information to individuals/family members

□ I authorize Alan F. Shikoh, M.D., P.C. to verbally release any or all my PHI to the following individuals:

Name	*Relationship to Patient*
Name	*Relationship to Patient*
Name	*Relationship to Patient*
Name	*Relationship to Patient*

I do not authorize Alan F. Shikoh, M.D., P.C. to release any or all my PHI to any individuals/family members except as set forth above.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices from Alan F. Shikoh, M.D., P.C. and I have been provided an opportunity to review how my medical information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my medical information:

Patient _____

Birthday_____ SSN # _____

Signature _____ Date _____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____ By _____