PATIENT RECORD OF DISCLOSURES

Chart # _____

I, _____, give my permission to discuss my PHI to the following person(s):

	NAME	RELATIONSHIP
1.	_____	_____
2.	_____	_____
3.	_____	_____

_____ _____ _____

Print Name Signature Date

I wish to be contacted in the following manner. (Check all that apply)

Home Telephone _____

_____ O.K. to leave message with detailed information

_____ Leave message with call back only

Written Communication

_____O.K. to mail to home address

_____ O.K. to mail to work address

_____ O.K. to fax to this number

Work Telephone _____

FAX # _____

_____ O.K. to leave message with detailed information

_____ Leave message with call back number only

OTHER _____

**If any of this information should change, it is your responsibility as our patient to notify TSDDC/Tri-State Gastroenterology Associates of these changes.

_____ _____ _____

Print Name Signature Date

RECORD OF NON-AUTHORIZED DISCLOSURES OF PROTECTED HEALTH INFORMATION

DATE	DISCLOSED TO:	PURPOSE OF DISCLOSURE	INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____