PATIENT RECORD OF DISCLOSURES

(In compliance with HIPAA)

Child's Name: _____ Date of Birth: _____

Parent's Name: _____

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

[ ] Home Telephone (____) ____-_____

- [ ] OK to leave message with detailed information
- [ ] Leave message with call back number only

[ ] Work Telephone (____) ____-_____

- [ ] OK to leave message with detailed information
- [ ] Leave message with call back number only

[ ] Written Communication

- [ ] OK to mail to my home address
- [ ] OK to fax to this number (____) ____-_____

[ ] Other

- [ ] _____
- [ ] _____

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Date	Disclosed to Whom (Address/Fax Number)	Description of Disclosure	Remarks