

# Avoiding Breaches of Confidentiality

(Request For Limitations and Restrictions of PHI)

**HIPAA** (Health Insurance Portability & Accountability Act of 1966; a federal law) requires healthcare organizations to comply with specific rules (Notice of Privacy Practices) regarding your **Protected Health Information (PHI)**.

With my consent, Eddy OB/GYN, PLC may use and disclose protected health information (PHI) about me to carry out treatment, obtain payment, and to further healthcare operations. Please refer to Eddy OB/GYN, PLC Notice of Privacy Practices for a more complete description of such uses and disclosures.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street Apartment  
City State Zip

I authorize Eddy OB/GYN, PLC and its staff and/or representatives to leave medical information pertaining to my care by the following methods:

***Please check Yes or No and Write Telephone Number(s)***

Home telephone (H)	No	Yes	Number: _____
Ans. machine (home) (HAM)	No	Yes	_____
Work telephone (W)	No	Yes	Number: _____
Voice Mail (work) (VM)	No	Yes	_____
Cell phone (C)	No	Yes	Number: _____
Pager (P)	No	Yes	Number: _____
Email (E)	No	Yes	Address: _____

We will try to honor your above request. However, if you do not give us a contact number, we will not be able to contact you with information regarding your care. Therefore, you will have to schedule an office visit appointment to discuss your results, whether normal or abnormal.

Please list names of people **we can discuss** your medical care with:

Spouse: \_\_\_\_\_ Parent: \_\_\_\_\_

Other (Name): \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient/Parent/Legal Guardian