HIPAA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

I understand that it is the policy of MD Neurology/Drew Neurology to restrict access to my Protected Health Information in accordance with federal law. The following may have access to my healthcare information:

1) The caregiver(s) providing health services

2) My insurance company(-ies) for payment of my claim

3) The person(s) indicated below:

Name(s) (Please Print)	**DOB**	**Information Access Preferences**
1. **Myself** (patient or legal guardian[1])	N/A	
2.		**Clinical Information**(please check one) ◯ All or ◯ Restricted*
3.		◯ All or ◯ Restricted*
4.		◯ All or ◯ Restricted*
5.		◯ All or ◯ Restricted*

*If you circle **Restricted** above, please specify what clinical information you do **NOT** wish to share with the person(s) in the above boxes:

- ☐ Sexually Transmitted Disease(s)
- ☐ Pregnancy
- ☐ Terminal Illness
- ☐ Mental/Behavioral Health
- ☐ Other_____

Communication preferences:

- ◯ I give consent for you to leave confidential clinical information on my answering machine
- ◯ I do **not** give consent for you to leave confidential clinical information on my answering machine

_____

Patient Signature Date Witness Signature

_____

Printed Patient Name Printed Witness Name

[1]Sate law permits both parents to have access to PHI unless we are provided a court order restricting this right