Rheumatology Associates of Central Florida, PA
3160 Southgate Commerce Blvd., Suite 30
Orlando, Florida 32806
Phone: 407-859-4540
Fax: 407-859-3815

Health Insurance Portability and Accountability Act (HIPAA)

PLEASE PRINT CLEARLY

PATIENT NAME: _____

PARENT OR SPOUSE NAME: _____

PREFERRED PHONE # _____

ADDRESS: _____

_____

EMAIL ADDRESS: _____

IN GENERAL, THE HIPAA PRIVACY RULE GIVES INDIVIDUALS THE RIGHT TO REQUEST A RESTRICTION OF THEIR HEALTH INFORMATION. THE INDIVIDUAL IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI (PROTECTED HEALTH INFORMATION) BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING INFORMATION TO THE INDIVIDUAL'S OFFICE INSTEAD OF THEIR HOME.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

HOME TELEPHONE:
OK TO LEAVE MESSAGE WITH DETAILS ☐
LEAVE MESSAGE WITH CALL BACK NUMBER ☐
AUTHORIZED PERSON TO SPEAK WITH _____

CELL PHONE:
OK TO LEAVE MESSAGE WITH DETAILS ☐
LEAVE MESSAGE WITH CALL BACK NUMBER ☐

WRITTEN COMMUNICATION:
OK TO MAIL TO MY HOME ☐

EMAIL:
OK TO SEND EMAIL WITH DETAILS ☐

WORK TELEPHONE:
OK TO LEAVE MESSAGE WITH DETAILS ☐
LEAVE MESSAGE WITH CALL BACK NUMBER ☐

I GIVE RHEUMATOLOGY ASSOCIATES OF CENTRAL FLORIDA, PA, PERMISSION TO USE AND DISCLOSE PHI NECESSARY TO CARRY OUT TREATMENT OR PAYMENT. BY SIGNING THIS FORM, I UNDERSTAND THAT THE PRIVACY PRACTICES OF THE OFFICE HAVE BEEN DISCLOSED TO ME.

SIGNATURE *X* _____ DATE _____