5020 Ritter Road, Suite 106
Mechanicsburg, PA 17055

Duncan Nulph
HEARING ASSOCIATES

www.dnhearing.com
717-766-1500

Patient Authorization of Disclosure

Patient Name: _____ **DOB:** _____

In general, the HIPPA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

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

Cell Phone

- ◯ OK to leave message with detailed information
- ◯ Leave message with call-back number only
- ◯ OK to text to cell phone listed on Patient Information Form

Home 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 email to my email address listed on Patient Information Form

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Duncan-Nulph Hearing Associates may discuss your healthcare and scheduling needs as well as billing issues that may arise.

☐ **Only disclose information to myself**

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Patient or Representative Signature _____ **Date** _____

Name of Representative & Relationship to Patient (parent, guardian, POA, etc) _____

☐ ***Patient refused to sign*** Staff _____ Signature _____ Date _____