INOVA®
Schar Cancer Institute

Breast Cancer Program

Patient Name _____

MRN: _____

DOB: _____

Patient Record of Disclosures

In general, the HIPAA 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 or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

Home Telephone: _____

- ☐ OK to leave a message with detailed information
- ☐ Leave message with call-back only

Cell Telephone: _____

- ☐ OK to leave a message with detailed information
- ☐ Leave message with call-back only

Work Telephone: _____

- ☐ OK to leave a message with detailed information
- ☐ Leave message with call-back only

Written Communication: _____

- ☐ OK to mail to my home address

Other: _____

It is OK for this office to share my medical information with:

- ☐ No one
- ☐ The following individuals:

Name: _____
Relationship: _____
Phone Number: _____
Address: _____

Name: _____
Relationship: _____
Phone Number: _____
Address: _____

Name: _____
Relationship: _____
Phone Number: _____
Address: _____

Names and addresses of Physicians that you would like to receive a report of this visit:

Physician	Specialty	Address	Fax #

Patient Signature: _____