Brick Psychiatric Services, Inc.

HIPAA Authorization

HIPAA: Patient Restriction of Disclosures

The HIPAA privacy rule gives you, the patient, the right to request a restriction on uses and disclosures of your protected health information. Please carefully complete the following statement by initialing all options that apply:

I may be contacted in the following manner:

Cell Phone	**Work Phone**	**Home Phone**	**Written**
☐ Detailed Message	☐ Detailed	☐ Detailed	☐ Detailed
☐ Limited Message	☐ Limited	☐ Limited	☐ Limited

Best Contact Number: _____

HIPAA: Patient Designation of Disclosures

The HIPAA privacy rule gives you, the patient, the right to designate a person or persons to act on your behalf. Please carefully complete the following statement:

CHECK ONE OF THE BELOW STATEMENTS

☐ I hereby allow the following person(s) to be given information regarding my treatment. This information may be given solely to the people listed below through verbal communication, written communication or in person.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ I do not wish for anyone to be able to obtain information regarding my treatment.

I certify that I have read (or have read to me) the above statement and fully understand the content.

_____ _____

Signature of Patient / Parent / Guardian Date