CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected heath 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 & FILL OUT ALL THAT APPLY):

VERBAL COMMUN.	☐ **CELL PHONE :**	☐ OK TO LEAVE DETAILED MESSAGE ☐ LEAVE CALL BACK NUMBER ONLY[1]
	☐ **HOME PHONE :**	☐ OK TO LEAVE DETAILED MESSAGE ☐ LEAVE CALL BACK NUMBER ONLY[1]
	☐ **WORK PHONE :**	☐ OK TO LEAVE DETAILED MESSAGE ☐ LEAVE CALL BACK NUMBER ONLY[1]
WRITTEN COMMUN.	☐ **EMAIL :**	☐ OK TO SEND DETAILED MESSAGE ☐ REQUEST TO CONTACT US ONLY[1]
	☐ **FAX :**	☐ OK TO SEND DETAILED MESSAGE ☐ REQUEST TO CONTACT US ONLY[1]
	☐ **MAIL :**	☐ OK TO SEND DETAILED MESSAGE ☐ REQUEST TO CONTACT US ONLY[1]

[1] *UNLESS OTHERWISE SPECIFIED BY THE PATIENT, EXECUTIVE MD WILL LEAVE NON-DETAILED APPOINTMENT REMINDERS AT THE SPECIFIED METHOD.*

*It is acknowledged by the patient that email communication is not secure and all information passed via email runs the risk of being seen by other parties. In choosing to communicate medical information via unsecured emails and initiating an email conversation with the medical staff, you accept this risk, realizing other means of communication are available to you.

I GIVE EXECUTIVE MD THE PERMISSION TO DISCLOSE/DISCUSS MY MEDICAL INFORMATION WITH THE FOLLOWING INDIVIDUALS:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

NOTE: Uses and disclosures for Treatment, Payment & Operations may be permitted without prior consent in an emergency.

FULL NAME: _____ DOB: _____

PARENT/GUARDIAN (If under 18): _____

SIGNATURE:_____ DATE: _____

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Executive MD for as long as the PHI is maintained in the designated record set. You have the right to revoke this authorization, in writing, at any time, except to the extent that Executive MD has taken action in reliance on it. A revocation is effective upon receipt by Executive MD of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.