OLD DOMINION MEDICAL CENTER

6715 Whittier Avenue, Mclean, Va 22101

PATIENT RECORD OF DISCLOSURES

Chart # ______________

PATIENT INFORMATION

First Name:	M.I.	Last Name:	Date Of Birth: (MM/DD/YY)

To help meet all your healthcare needs, please fill out this form completely.
This is a confidential record of your medical history and will be kept with your medical record.

Patient Record of Disclosures

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 (Please check all that apply):

- ☐ Home Telephone #: ______________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

- ☐ Work Telephone #: ______________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

- ☐ Written communication
- ☐ O.K. to fax to this number: ______________

- ☐ Other: ______________________________

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Privacy Notice Acknowledgement

I hereby acknowledge that Old Dominion Medical Center's Privacy Notice was made available to me. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ______________________ Date: ______________

Print Name: ______________________