Request for Limitations and Restrictions of Protected Health Information

HRC Fertility

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____ *** Put in "Alert Notes"**

Name _____ Date of Birth _____

This form is for our own internal purposes only and is in compliance with the HIPAA Act. We need documentation to verify the most successful ways of communicating with you.

What are the best numbers to contact you? Please provide two options in case we are not able to reach you at one of the numbers:

❑ Home phone # _____

Is it okay to leave a message? ❑ Yes ❑ No

❑ Work phone # _____

Is it okay to leave a message? ❑ Yes ❑ No

❑ Cell phone # _____

Is it okay to leave a message? ❑ Yes ❑ No

❑ Fax home # _____

❑ Fax work # _____

❑ Email – Primary _____

(this email will be used for all email communication contact from HRC unless you elect not to receive as specified below)

❑ I do not wish to receive clinical and billing emails

❑ I do not wish to receive the HRC e-Newsletter

❑ I do not wish to have my anonymous demographic information used by HRC's marketing division.

❑ I do not wish to receive HRC social media (Facebook, Twitter, etc.)

❑ Email – Secondary/E-mail _____

Comments _____

_____

❑ **I give permission for my partner to receive my test results.**

Signature of Patient _____ Date _____

Signature of Partner _____ Date _____