OAK PARK MEDICAL CLINIC
1301 WHITE DR
BATESVILLE, AR 72501
870-793-6887

Request for limitations and restrictions of protected health information

Patient Name: _____

How would you prefer that we communicate your protected health information (PHI) with you if you cannot be reached directly? Your PHI includes general health information, laboratory test, diagnostic test results, appointment reminders, and patient demographic, billing information.

Please answer the following questions by marking YES or NO.

1. Is it ok to leave messages on your home answering machine: YES___NO___
2. Is it ok to leave message on your work voice mail? YES___NO___
3. Do you want us to contact you by cell phone and/ or leave a message on your cell phone voice mail? YES___NO___ If yes please provide number:_____
4. Is it ok to leave messages with your spouse or domestic partner? YES___NO___
5. Is it ok to leave messages with your son/daughter over 18 years of age? YES___ NO___
6. Is it ok to mail protected health information to your home? YES___NO___

Please list any exception(s) to the above: _____

_____

Sensitive information such as HIV results, STD results, abnormal results and diagnoses will not be left as messages. Information regarding sexually transmitted diseases will only be released to the patient.

The information discussed between you and your healthcare provider is strictly confidential. Please indicate below any individual(s) allowed to accompany you into the exam room and /or receive your medical information.

_____ _____

_____ _____

I have reviewed and I understand this form. Please sign below.

Patient or Patient Representative: _____Date_____

Witness: _____ Date: _____