ARTHRITIS CENTER *of* ORLANDO
1550 Citrus Medical Court
Ocoee, FL 34761
Tel 407 757 2777 Fax: 407 757 0271

Health Insurance Portability and Accountability Act (HIPAA)

PLEASE PRINT CLEARLY

Patient Name: _____
Parent or Spouse Name: _____
Preferred Phone# _____
Address: _____
Email Address: _____
Authorized person to Speak with _____

In General, The HIPPA Privacy Rule Gives Individuals The Right To Request A Restriction Of Their Health Information. The Individual Is Also Provided The Right To Request Confidential Communications Or That A Communication Of PHI (Protected Health Information) Be Made By Alternative Means, Such As Sending Information To The Individual's Office Instead Of Their Home.
I have read and understood the Office Privacy notice

I Wish To Be Contacted In The Following Manner (Check All That Apply):

Home telephone:

Ok to leave message with details ☐
Leave message with call back number ☐

Cell Phone:

Ok to leave message with details ☐
Leave message with call back number ☐

Email:

Ok to send email with details ☐
I give Arthritis Center of Orlando permission to use and disclose the necessary PHI to carry out treatment or payment. By signing this form, I understand that the Privacy practices of the office have been disclosed to me.

_____ _____
Signature Date