PATIENT RECORD OF DISCLOSURES

PREMIER WOMEN'S CARE

920 Medical Plaza Dr., Suite 530 The Woodlands, TX 77380

Telephone: (281) 825-4900

NAME		□F	BIRTHDATE	PAGE				
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	l wish to b	e conta	cted in the follow	ing manner	(check all that ap	ply):		
⊓Но	me Telephone			-	Communication			
☐ O.K. to leave message with detailed information				☐ O.K. to mail to my home address				
☐ Leave message with call-back number only				□ O.K. to mail to my work/office address				
				O.K. to fax to this number				
□Wo	rk Telephone							
	☐ O.K. to leave message w			☐ Other _	· - -			
	Leave message with call	-back nu	ımber only					
Patient Signature					Date			
	Red	ord of I	Disclosures of Pr	otected Hea	Ith Information			
Date	Disclosed To Whom Address or Fax Number	(1)	Description of I Purpose of Di	Disclosure/ sclosure	By Whom Di	sclosed	(2)	(3)
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- (1) Check this box if the disclosure is authorized
- (2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations; A=Authorization on File; D=Discretionary
- (3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other