

Jan. 2006

**RICHARD G. BUCH M.D.
HIPPA INFORMATION SHEET**

WHOM TO CONTACT:

I HEREBY GIVE PERMISSION TO RICHARD G. BUCH M.D. TO DISCLOSE AND DISCUSS ANY INFORMATION RELATED TO MY MEDICAL CONDITION(S) TO/WITH THE FOLLOWING FAMILY MEMBER(S), OTHER RELATIVE(S) AND/OR CLOSE PERSONAL FRIEND(S):

NAME: _____
RELATIONSHIP: _____
PHONE NUMBER(S): _____

NAME: _____
RELATIONSHIP: _____
PHONE NUMBER(S): _____

NAME: _____
RELATIONSHIP: _____
PHONE NUMBER(S): _____

° I DO NOT WISH TO GIVE PERMISSION FOR ADDITIONAL FAMILY MEMBERS, RELATIVES AND/OR CLOSE PERSONAL FRIENDS TO HAVE ACCESS TO ANY INFORMATION REGARDING MY MEDICAL CONDITION(S)

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

HOME # _____
WORK # _____
CELL # _____

- ° OK TO LEAVE MESSAGE WITH DETAILED INFORMATION @ HOME
- ° OK TO LEAVE MESSAGE WITH CALL BACK NUMBER ONLY @ HOME
- ° OK TO LEAVE MESSAGE WITH DETAILED INFORMATION @ WORK
- ° OK TO LEAVE MESSAGE WITH CALL BACK NUMBER ONLY @ WORK
- ° WRITTEN COMMUNICATION ONLY
- ° OK TO SEND MAIL TO HOME ADDRESS
- ° OK TO SEND MAIL TO WORK/OFFICE ADDRESS @:

° OK TO FAX TO THIS NUMBER _____

THE DURATION OF THIS AUTHORIZATION IS INDEFINITE UNLESS OTHERWISE REVOKED IN WRITING. I UNDERSTAND THAT REQUESTS FOR MEDICAL INFORMATION FROM PERSONS NOT LISTED ABOVE WILL REQUIRE A SPECIFIC AUTHORIZATION PRIOR TO DISCLOSURE OF ANY MEDICAL INFORMATION.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

DATE: _____