HIPAA PRIVACY RESTRICTIONS QUESTIONNAIRE
CONNECTICUT BACK CENTER

Patient Name: _____ Date of Birth: _____/_____/_____

May we send statements and reminder cards to your home? ( ) YES ( ) NO

If "NO", what address should we use? _____

_____

May we leave messages (including test results) on your answering machine? ( ) YES ( ) NO

May we send you a fax? ( ) YES ( ) NO

May we contact you via email? ( ) YES ( ) NO
E-mail address: _____

Please list the names and relationship of the persons who we may release information about your medical care:

_____

_____

_____

Pediatric Patients: Only Contact ( ) Mother ( ) Father ( ) Legal Guardian

Names of all children to **whom these restrictions apply:**

_____

_____

_____

_____
Signature of Patient or Legal Guardian **Date**

FOR RESTRICTIONS TO YOUR PROTECTED HEALTH INFORMATION (PHI) OTHER THAN NOTED ABOVE, PLEASE SUBMIT IN WRITING TO THE COMPLIANCE/PRIVACY OFFICE UTILIZING OUR "RESTRICTION OF USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION" (PHI) FORM.