HIPAA DISCLOSURE FORM

In order to comply with specific rules regarding HIPAA (Health Insurance Portability & Accountability Act of 1996), we ask that our patients complete and sign this privacy and security of health information form.

Name: ___________________________ Date: ___________________________

It is not the policy of Dr. John Boston’s office to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voicemail, or cell phone. Whenever returning telephone calls and the answering machine picks up we cannot leave a message if the name and telephone number are not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I authorize Dr. John Boston’s office to leave medical information pertaining to my care by the following methods and will assume responsibility of notifying Dr. Boston’s office whenever this information changes.

Home Telephone
☐ Yes ☐ No ☐ N/A
Answering Machine
☐ Yes ☐ No ☐ N/A
Work Telephone
☐ Yes ☐ No ☐ N/A
Cell Phone
☐ Yes ☐ No ☐ N/A
Text Message
☐ Yes ☐ No ☐ N/A
E-Mail Address ____________________________________________ ☐ Yes ☐ No ☐ N/A

*Due to open Internet Access, the security of content sent through email cannot be guaranteed secure.

Signature: ________________________________

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AUTHORIZATION FORM

If you would like to allow us to speak, or have information released to someone other than yourself, please complete the following by listing the names of people authorized to receive your health information.

Name: ______________________ Relation: ______________________

Name: ______________________ Relation: ______________________

Name: ______________________ Relation: ______________________

I understand that upon request I can receive copies of the Office Policies and Notice of Privacy Practices for the office of Dr. John Boston.

Print Name: ______________________ Date: ____________

Signature: ______________________