



NEW PERSPECTIVES HEALTH CARE, LLC

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**Patient Record of Disclosures: HIPAA (Health Information Portability and Accountability Act of 1996) Privacy Rule**

HIPAA regulations provide for the protection of your health records and information. You also have the right to request confidential private health information communication by alternate means. This may include your authorization to communicate personal health information to the following persons:

Please list family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis which may include treatment, payment and health care operations.

Name: \_\_\_\_\_ Phone number \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number \_\_\_\_\_ Relationship: \_\_\_\_\_

IN AN EMERGENCY ONLY: Please contact one or all of the following family members or other persons designated with concerns regarding general medical condition:

Name: \_\_\_\_\_ Phone number \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number \_\_\_\_\_ Relationship: \_\_\_\_\_

Please print the name and address of whom you would like your billing statements and/or correspondence from our office to go to IF OTHER THAN YOUR HOME OF RECORD.

\_\_\_\_\_

Can messages be left on your home phone number or voice mail? Yes \_\_\_\_\_ No \_\_\_\_\_

Can messages be left on your cell phone? Yes \_\_\_\_\_ No \_\_\_\_\_

Patient Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

02/2009