

# Patient Contact Information Restriction



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**Patient Name**

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**Patient Date of Birth**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or alternative means of communicating PHI, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner **(please check all that apply)**:

**Cell Phone:** \_\_\_\_\_

OK to leave message with detailed information

Leave Message with call back number only

**Home Phone:** \_\_\_\_\_

OK to leave message with detailed information

Leave Message with call back number only

**Work Phone:** \_\_\_\_\_

OK to leave message with detailed information

Leave Message with call back number only

**Written Communication**

OK to mail to my home address

OK to mail to my work/office address

OK to fax to \_\_\_\_\_

Other \_\_\_\_\_

I understand this authorization will be in effect until which time it is revoked.

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**Patient Signature**

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**Today's Date**