David M. Butler, M.D.. F.A.C.S.
American Board of Facial Plastic and Reconstructive Surgery

PATIENT CONTACT INFORMATION / RESTRICTION

In general, the HIPAA privacy rule gives individuals the right to request a restriction onuses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individuals' office instead of their home. I wish to be contacted in the following manner (Check all that apply):

____ **Home Telephone**_____
_____ OK to leave message with detailed information.
_____ Leave message with call back number only.

____ **Cell Telephone**_____
_____ OK to leave message with detailed information.
_____ Leave message with call back number only.

____ **Work Telephone**_____
_____ 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 fax to_____

____ **E mail**_____

I hereby consent to the release of Protected health Information to the following individuals.
I understand this authorization will be effective until which time it is revoked.

NAME	RELATIONSHIP
_____	_____
_____	_____

_____ _____
Patient's/Guardian Signature Date

_____ _____
Print Name Birthdate

1301 TWENTIETH STREET SUITE 300 SANTA MONICA, CALIFORNIA 90404-2053 (310) 829-7792 FAX (310) 829-4136

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