LAURIE R. REED, M.D.

Board Certified
Psychiatry

43 Eagle Ridge Road
Lebanon, NH 03766
t: 603-448-0790
f: 603-448-9822
laurie.r.reed@gmail.com
www.drlauriereed.com

PATIENT DISCLOSURE FORM

In general, the federal privacy rule (known by its acronym HIPPA) gives individuals the right to request a restriction on the uses and disclosures of their protected health information. The individual also has the right to restrict the means by which confidential communications are dispatched. Please indicate below which forms of communication you will allow.

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
- ◯ Do not leave a message

☐ CELLULAR TELEPHONE ( ) _____
- ◯ OK to leave message with detailed information
- ◯ Leave message with call back number only
- ◯ Do not leave a message

☐ WORK TELEPHONE ( ) _____
- ◯ OK to leave message with detailed information
- ◯ Leave message with call back number only
- ◯ Do not leave a message

☐ WRITTEN COMMUNICATION
- ◯ OK to mail to my home address
- ◯ OK to mail to my work address
- ◯ OK to fax to this number: ( ) _____
- ◯ OK to email to this address: _____

☐ WHO CAN I CONTACT IN CASE OF AN EMERGENCY?
- ◯ OK to contact by phone: ( ) _____
- ◯ OK to contact by email: _____

_____

SIGNATURE DATE