EASTERN CAROLINA MEDICAL CENTER
PATIENT FORM TO REQUEST STRICTER PRIVACY CONTROL

In order to respect your privacy and the confidentiality of your Protected Health Information (PHI), Eastern Carolina Medical Center has developed this foam to help us better serve you. As you are already aware, the Federal Government required us as of April 2003 to implement stricter practices to protect your privacy. These stricter practices are a result of a law referred to as HIPAA. Eastern Carolina Medical Center HIPAA Privacy Practices are outlined and explained in. the *office* Notice of Privacy Practices that you have already received. HIPAA regulations do allow us to discuss matters about you and your care at this office with your close relatives and close personal friends. We are, however, **bound under** HIPAA to use our best professional judgment in making these disclosures, and also to disclose only the minimum necessary amount of information in order to convey a message. For example, if a husband and wife, or a mother and daughter, always come to appointments at the office together and are sometimes seen by the doctor together, it is a reasonable assumption that the patient is comfortable with their relative knowing health information about them. This is a perfectly allowable scenario under HIPAA regulations.

However to assure that we are disclosing information about you only to those people that you have designated, we ask that you take a moment to complete this form. Please list the names and associated information of 4 people (maximum) that we may disclose information to concerning your care at our office. Realize that upon your request receipt we will only disclose information to you or to those you have listed below. Please be aware Eastern Carolina Medical Center. does reserve the right to make disclosures of health information about you if required by law for various reasons that are addressed in our-Notice ,of Privacy Practices and also in the' event of an emergency. Please return this completed form today at the checkout desk.

1. Name:
   Phone#:
   Relationship:

2. Name:
   Phone#:
   Relationship:

3. Name:
   Phone#:
   Relationship:

4. Name
   Phone#:
   Relationship:

*SIGN HERE IF YOU DO NOT WISH FOR US TO SHARE INFORMATION WITH ANYONE.

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Patient Name: DOB: Chart#:
Date Received: enacted on 12/8/03