Diagnostic Neurology
Clinic of Houston

Joanne Y. Kim, MD

FRONT OFFICE: 713.467.8491

PATIENT RECORD OF DISCLOSURES

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

_____ Home Telephone: _____

Okay to leave a message with detailed information? YES NO

_____ Cell Phone: _____

Okay to leave a message with detailed information? YES NO

_____ Work Phone: _____

Okay to leave a message with detailed information? YES NO

Written Communication:

Okay to mail to home address? YES NO

Okay to mail to work address? YES NO

Okay to fax? YES NO SECURE FAX NUMBER: _____

PERSONS TO WHOM INFORMATION MAY BE DISCLOSED

In the space below, please list names, phone numbers and relationship of any family members or individuals you give us permission to speak with regarding your medical treatment and billing inquiries:

Name: _____ Relation: _____ Telephone: _____

Name: _____ Relation: _____ Telephone: _____

Name: _____ Relation: _____ Telephone: _____

Name: _____ Relation: _____ Telephone: _____

Name: _____ Relation: _____ Telephone: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I am able to receive and read a copy of the Notice of Privacy Practice from Diagnostic Neurology Clinic of Houston. I have also been given the opportunity to ask questions about this notice. My signature below confirms that this has been provided to me and I can request a copy.

_____ _____

Signature of Patient or Parent/Guardian Date