

**SUFFOLK NEPHROLOGY CONSULTANTS, P.C.**

**Nephrology & Hypertension Specialists**

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**PATIENT CONTACT INFORMATION SHEET**

In general, the HIPPA 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 a communication of PHI to be made by alternative means, 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.)

**Home Telephone:** \_\_\_\_\_  Written Communication  
 OK to leave message with detailed information  OK to mail to my home  
 Leave message with call back # only  OK to mail to my work

**Cell Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**Work Number:** \_\_\_\_\_  OK to fax to this number  
 OK to leave message with detailed info  
 Leave message with call back number only  
 OK to fax shared info to all my doctors, as needed

**E-MAIL Address:** \_\_\_\_\_

**THIRD PARTY CONTACTS**

The **primary** person I wish to have access to my information in regards to my medical condition is:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_ Street \_\_\_\_\_  
Town/State/Zip Code \_\_\_\_\_

The **alternate** person I wish to have access to my medical information is:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_ Street \_\_\_\_\_  
Town/State/Zip Code \_\_\_\_\_

I have read and understand the above information and acknowledge that these directions are considered in effect until I notify Suffolk Nephrology Consultants in writing about any changes.

**PATIENT NAME**  
(PRINT) \_\_\_\_\_ **DATE** \_\_\_\_\_

**PATIENT SIGNATURE/LEGAL REPRESENTATIVE** \_\_\_\_\_  
(patient contact information and HIPPPA form Rev. 10/10/2014)