Associates in Dermatology, PLLC

Receipt of Notice of Privacy Practices Written Acknowledgement

I have received a copy of the Privacy Practices provided by Associates in Dermatology, PLLC.

_____ _____
Print Name Date of Birth

_____ _____
Signature of Patient / Parent or Guardian Date

My Protected Health Information may be disclosed to:

❒ Self Only

❒ Spouse / Significant Other: _____ Phone #: _____

❒ Parent / Guardian: _____ Phone #: _____

❒ Roommate: _____ Phone #: _____

❒ Other: _____ Phone #: _____

❒ Children: _____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

I give permission for Associates in Dermatology to contact me at work regarding test results.

❒ **Yes** ❒ **No** **Work #:** _____

I give permission for Associates in Dermatology to leave a message regarding test results on the following:

❒ Home answering machine / voice mail

❒ Cell phone voice mail Cell #: _____

❒ Work voice mail