Advanced Dermatology Center P.C.

Receipt of Advanced Dermatology Center Notice of Privacy Practices

I acknowledge receipt of The Advanced Dermatology Center, P.C.'s Notice of Privacy Practices for Protected Health Information.

Patient/Responsible Party Signature: _____ Date ___/___/___

Patient Communication Form

Family and Friends. It is the office policy of Advanced Dermatology Center not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by patient, (iii) as we may reasonably infer from the circumstance (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse:_____

Parent:_____

Other:_____

Patient Signature:_____ Date:_____

If you wish to **DECLINE** to designate another person to speak with the physician or clinical staff, please sign below

Patient Signature:_____ Date:_____