



NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Notice of the Privacy Practices. I understand that I may obtain a written copy of this Notice at any time upon request.

Name of Patient

Date of Birth

Patient/Guardian's Signature

Date

Witness

Date

Reason Given by Patient if Refusing to Sign this Notice _____

Recorder's Signature _____

Instructions for Communication:

I authorize my doctor or staff to **leave messages** including certain medical information:

- YES** On my answering machine or voice mail:
 - at HOME at WORK on my MOBILE/CELL Phone

OR with the following individuals:

- My spouse or significant other _____
- My son or daughter _____
- Any relative _____
- Other _____

This information may include information such as:

- Pathology/Lab results Instructions regarding treatments or medications
- Information regarding prescription refills
- Information regarding appointments
- Information regarding billing/insurance

- NO** I prefer that my doctor or staff speak to me personally regarding any medical information. Please **do not leave messages** concerning medical information.

I understand that I may notify Lake Dermatology at any time of changes to this request, which would require a new form to be completed.

Signature

Date