MIDTOWN DERMATOLOGY

HIPAA PRIVACY AUTHORIZATION
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Patient Name: _____ **Date of Birth:** _____

Confidential Communication Request

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have the right to request that communication concerning your personal health be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I, *(print your full name)* _____, hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment, or payment for services. **This request supersedes any prior request for confidential channel communication I may have made.**

Contact Information:

Home #: _____ ☐ Do ☐ Do Not Leave messages on my voicemail

Cell #: _____ ☐ Do ☐ Do Not Leave messages on my voicemail

☐ Do ☐ Do Not Send text messages (appointment reminders)

Work #: _____ ☐ Do ☐ Do Not Leave messages on my voicemail

☐ Do ☐ Do Not Leave message with any other person

Email: _____ (appointment reminders)

Please list other persons that may be contacted with confidential communications:

Name: _____ Relationship to patient: _____ Phone #:_____

Name: _____ Relationship to patient: _____ Phone #:_____

Name: _____ Relationship to patient: _____ Phone #:_____

By signing this form, I acknowledge that I have received a copy of Midtown Dermatology's Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

If not signed by the patient, please indicate the relationship:

____*Parent/Guardian of a minor*
____*Guardian or conservator of an incompetent patient*
____*Beneficiary or personal representative of a deceased patient*
____*Other (specify):* _____