PATIENT DISCLOSURE INFORMATION

In general, the HIPAA 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 communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ **Phone Number** – **Home** _____

Cell phone _____

Work phone _____

☐ Can leave detailed information
(**such as all medical/billing info**)

☐ Can leave limited information
(**such as benign/bloodwork results/billing info**)

☐ Leave call back number only

☐ **Written communication**

☐ E-mail _____

☐ Fax _____

☐ Home Address _____

_____

☐ Emergency Contact (if different from below):

_____

Other: _____

☐ **Persons authorized to receive information**

_____ Relationship _____ Phone _____

☐ **Medical** ☐ **Billing**

_____ Relationship _____ Phone _____

☐ **Medical** ☐ **Billing**

_____ Relationship _____ Phone _____

☐ **Medical** ☐ **Billing**

_____ _____ _____
Name Signature of Patient/Parent Date

ACKNOWLEDGEMENT OF RECEIPT OF
KUFLIK DERMATOLOGY CENTER
NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received/read a copy of the Kuflik Dermatology Center Notice of Privacy Practices.

_____ _____ _____
Name Signature of Patient/Parent Date

Kuflik Dermatology Center Use Only
Date acknowledgement received: _____
-OR-

Reason acknowledgement was not obtained: _____