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: ______________________________________