MD | MOORE DERMATOLOGY ASSOCIATES

PRIVACY PRACTICES NOTICE ACKNOWLEDGEMENT FORM & REQUEST FOR CONFIDENTIAL COMMUNICATION

My signature below, acknowledges that the medical practice of Moore Dermatology has provided a Privacy Practices notice to me (posted in waiting room). I also acknowledge that the Privacy Practices Notice adequately describes how this medical practice assures the safety of my protected health information, and adequately explains my rights to privacy regarding the medical care I am seeking.

I request Moore Dermatology to keep communications regarding my protected health information confidential. To accomplish this request please adhere to the following requests:

PHONE: You can contact me by phone: HOME# _____ WORK # _____ CELL#_____

From the numbers above, which is the best number to reach you? ____HOME ____WORK____ CELL

Leave detailed message **(including test results**) on answering machine: _____Yes _____NO

Leave message with another person: _____YES _____No

If "Yes", who? _____ Relationship? _____
Phone number if different: _____

EMAIL: _____ please contact me by EMAIL address _____

In regards to: detailed messaged regarding results _____Yes _____No
In regards to: billing _____Yes _____No
In regards to: appointment reminders _____Yes _____No
In regards to: promotional specials _____Yes _____No

EMERGENCY CONTACT: Name: _____ Phone number _____
If you cannot reach me at the numbers above, please call my Emergency Contact ____Yes ___No

MAIL: Contact me at my home address unless otherwise indicated here: _____

Other requests for Confidential Communications: _____

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient. _____

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