ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practice provides information about how we may use and disclose your protected health information (PHI). It discusses your rights as a patient and Burnett Dermatology's duties with respect to your PHI. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

_____________________________ _________________
Print name ***Date of Birth***

____ ___________________________
Signature of Patient or Legal Representative ***Today's Date***

CONFIDENTIAL COMMUNICATIONS REQUEST FORM

We highly value your right to privacy. Please be aware that it is our policy to call both your home phone and cell phone numbers in order to:

- Confirm appointments
- Leave medical instructions and information
- Leave messages containing laboratory results including ***biopsy results***
- Return your calls

I prefer to share my medical / administrative information with the following person(s).

Name	***Phone number***
____________________________________	________________________
____________________________________	________________________

Please indicate any special restrictions you would like to follow, below: (Initial all that apply)

____ DO NOT leave messages on my home answering machine.

____ DO NOT leave a message with a family member/friend at my home telephone number.

____ DO NOT leave a message with my employer to return a call to this office.

____ DO NOT call my cell phone and disclose information on voicemail.

____ DO NOT disclose any/all information (except where prohibited by law) to the following Person(s): ____.

____ OTHER (please specify):____.

I may revoke or change this authorization at any time by completing another form. Please refer to the complete Privacy Notice available upon request.

____ ________________________
Signature of Patient or Legal Representative ***Date***