Dermatology Specialists of Monmouth County
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ACKNOWLEDGMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

Designation of Certain Relatives, Close Friends and Other Caregivers:

A. I agree that the practice may disclose certain parts of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. The Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment related to my health care. I wish to be contacted in the following manner:

Telephone, Written and Fax Communication To Relay Biopsy and/or Laboratory Results

Preferred Telephone Number: ______________________________

☐ OK to leave a message with detailed information

☐ Leave message with call back numbers only

Written Communication:

☐ OK to mail to my home address

☐ OK to fax to this number

B. I designate the following persons listed below as persons involved with my health care or payment related to my healthcare for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: ______________________ Relationship: ______________________

Print Name: ______________________ Relationship: ______________________

Print Name: ______________________ Relationship: ______________________

Acknowledgment of Practice's Notice of HIPAA Privacy:

I am aware of the Privacy Practices currently in effect for the above-named physician practice

SIGNATURE OF PATIENT/PARENT

Print Name of Patient ______________________ Date of Birth ____________

Date ____________

SIGNATURE OF PATIENT/PARENT

Print Name of Patient ______________________ Date of Birth ____________

Date ____________

SIGNATURE OF PATIENT/PARENT

Print Name of Patient ______________________ Date of Birth ____________

Date ____________