



**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 O'Donoghue 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 and biopsy results
- Return your calls
- Postcard reminders

**I prefer you to share information with the following:**

Name	Phone #
_____	_____
_____	_____
_____	_____

**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**