Authorization to Disclose Protected Health Information

Patient Name (print): _____ DOB: _____/_____/_____

Authorization to leave personal medical information by alternative means – check all that apply:

❑ May send personal medical information via an **e-mail message** to the address provided on my Registration Form. I understand that e-mail may not be a secure means of communication.	
❑ May leave a detailed message on voicemail at the **home** phone number provided on my Registration Form.	
❑ May leave a detailed message on voicemail at the **work** phone number provided on my Registration Form.	
❑ May leave a detailed message on the **cellular** phone number provided on my Registration Form.	
❑ May leave a detailed message at a different location	Location: Phone Number: ( )
❑ May leave a detailed message with spouse/partner	Name of Spouse/Partner: Phone Number: ( )
❑ May leave a detailed message with a family member or other individual	Name & Relationship: Phone Number: ( )

Signature: _____ Date: _____/_____/_____

Acknowledgement of Receipt of Privacy Practices

I am a patient of Bainbridge Skin Surgery.
I hereby acknowledge receipt of Bainbridge Skin Surgery's Notice of Privacy Practices.

Patient Name (print): _____ DOB: _____/_____/_____

Signature: _____ Date: _____/_____/_____

OR

I am a parent or legal guardian of _____ [patient name].
I hereby acknowledge receipt of the Bainbridge Skin Surgery's Notice of Privacy Practices with respect to the patient.

Name (print): _____

Relationship to Patient: ❑ Parent ❑ Legal Guardian

Signature: _____ Date: _____/_____/_____