KNOTT STREET
DERMATOLOGY

Notice of Privacy Practices Written Acknowledgement Form

As a patient of Knott Street Dermatology, I hereby acknowledge receipt of access to Knott Street Dermatology's Notice of Privacy Practices:

Patient Name: _____

Signature: _____

Date: _____

If above signed is other than patient, please list representatives name and relation below:

_____ _____

Name Relationship to Patient

H.I.P.A.A Consent of Communication

H.I.P.A.A (Health Insurance Portability and Accountability Act) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method. To protect the privacy and confidentiality of your information, please complete the following form to tell us how you wish to be contacted and with whom we may discuss your healthcare, insurance, and account/billing information/questions.

You may Contact me at the following Numbers: (please list all numbers that apply)

Home: _____ Mobile: _____

☐ Yes; you may leave FULLY DETAILED messages at: Home ____Mobile ____

☐ Yes; you may leave MINIMUM necessary information at: Home ____ Mobile____

I release the following individual(s) listed below to be provided confidential information by the Knott Street Dermatology

_____	_____	_____
Name	Phone	Relationship
_____	_____	_____
Name	Phone	Relationship

☐ If you do **NOT** wish your primary care provider to receive a copy of your chart note, please check this box.

Our office will continue to communicate with you per your above responses until you change your preferences. We will continue to leave appointment confirmations on your primary phone number. you can make a change by completing a new form. By signing below, you grant permission to the method of communication outlined above.

_____ _____

Signature of Patient (or Representative) Date