PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. I acknowledge that I have received *Advanced Dermatology and Skin Cancer Center's* Rights and Responsibilities policy and have been offered a copy of the entire HIPAA privacy notice. This notice is available at all times at *Advanced Dermatology and Skin Cancer Center*. I may request a copy of it at any time by contacting the Office Manager at 330-965-8760.

Current Home Phone Number ______________________ Current Cell Phone Number ____________________

Current Work Phone Number ______________________

Current Home Address: ____

I wish to be contacted in the following manner (check all that apply):

____ Home Telephone ______________________

____OK to leave message with detailed info

____Leave message with a call back only

____ Cell Telephone ______________________

____OK to leave message with detailed info

____ Leave message with a call back only

____ Work Telephone ______________________

____OK to leave message with detailed info

____Leave message with a call back only

____ Written Communication __________________

____ OK to mail to my home address

You may discuss my health information with:

NAME	RELATIONSHIP	PHONE
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

____ ____________________

Patient Signature Date

____ ____________________

Printed Name Date of Birth

Advanced Dermatology & Skin Cancer Center