LEHIGH VALLEY DERMATOLOGY ASSOCIATES, LTD.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

Address: _____

Practice Name: Lehigh Valley Dermatology Associates, Ltd.

I have been given a copy of Lehigh Valley Dermatology's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Lehigh Valley Dermatology has the right to change this notice at any time. I may obtain a current copy by contacting the Regulatory Compliance Manager's email (audrey@lehighvalleyderm.com), or by visiting the Lehigh Valley Dermatology's web site at **lehighvalleyderm.com.**

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practice:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement,* or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the Acknowledgement:

_____

_____

Completed by:

_____ _____
Signature of Practice Representative Date

HIPAA PATIENT COMMUNICATION FORM

A. Family and Friends: It is the office policy of Lehigh Valley Dermatology Associates not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment, (iv) in emergency situations or (v) other, as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below. If you do not want any of your medical information provided to a family member, please check (✓) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this in writing or call our staff.

Spouse: _____ _____ No

Parent: _____ _____ No

Other: _____ _____ No

_____ _____ No

_____ _____ No

B. Alternative Communications: You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

_____

_____

PRINTED NAME: _____

Patient/Parent/Guardian Signature: _____

Date: _____

FOR OFFICE USE

Changes to above authorized by patient over the phone:

Change	Date	Staff Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____