Lehigh Valley Dermatology Associates, LTD.

190 Brodhead Rd., Suite 205
Bethlehem, PA 18017

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
(Please print patient name here)

_____
(Signature)

_____
(Date)

_____
(Street Address)

_____
(Phone number)

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name: _____ Phone number: _____

Name: _____ Phone number: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (Please provide specific details)

_____
_____
_____

_____ _____
Patient Signature Date

_____ _____
Employee Signature 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
_____	_____	_____
_____	_____	_____
_____	_____	_____