Lake
DERMATOLOGY, INC.

This Form will need to be updated yearly. **Chart#:_____**

Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I authorize my doctor or staff to **leave messages** including information such as: Pathology/ Lab results, Instructions regarding Treatments of medications, Information regarding prescriptions refills, appointments, and billing/insurance.

☐ **YES** ON my answering machine or voice mail:
☐ at HOME ☐ at WORK ☐ on my MOBILE/CELL Phone

OR with the following individuals (list names of those we can speak with):
☐ My Spouse or significant other_____
☐ My son or daughter_____
☐ Any relative_____
☐ Other_____

☐ **NO** I prefer that my doctor or staff speak to me personally regarding any medical information. Please **do not leave messages** concerning medical information.

I authorize the medical staff to access my electronic medical record to download medications into my chart. I will still be asked to confirm current medications during my office visit.

☐ **YES** You have my permission to download my medication list.
☐ **NO** I prefer you not download my medication list.

I understand video/voice recordings are not permitted at Lake Dermatology.

I understand that in order to enhance the continuity of my health care, a copy of the notes from my visit at Lake Dermatology may be sent to my Primary Care Provider and/or my referring provider unless I specify otherwise by signing the Request for Limitations and Restrictions of Protected Health Information form. (To obtain a copy of this form please see the front desk office staff.)

By signing below, I acknowledge that I have received a copy of the Notice of the Privacy Practices. I understand that I may obtain a written copy of this Notice at any time upon request.
I understand that I may notify Lake Dermatology in writing at any time of changes to this request, which would require a new form to be completed.

_____ _____
Responsible Party Signature Date