

Patient Privacy Questionnaire and Notification

Patient Name: _____ Date of Birth: _____

I give permission to the physicians and their staff at Knoxville Center for Dermatology & Plastic Surgery to leave messages regarding my healthcare in the following manner when I am not available:

Contact Information:

I would prefer to be contacted at: _____ Home

_____ Cell

_____ Work

_____ Other

_____ May ONLY leave information with me (if you check here, no other choice should be marked).

_____ May leave appointment reminders on my voicemail.

_____ May leave NORMAL lab results on my voicemail.

_____ May leave general questions/information on my voicemail.

_____ May leave a message with a call back number ONLY.

Please list the name of the individual and relationship of information we may give information to:

Name: _____

Relationship: _____ # _____

Name: _____

Relationship: _____ # _____

_____ May leave appointment reminders with the above listed person.

_____ May leave NORMAL lab results with the above listed person.

_____ May leave general questions/information with the above listed person.

_____ May discuss billing information with the above listed person.

_____ I prefer that all healthcare messages be given to the above listed person.

If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health

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information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice and that I should read it carefully. I am aware that the Notice may be changed at any time.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary.

Signature of Patient _____ Date _____