PUGET SOUND
DERMATOLOGY
BOARD CERTIFIED DERMATOLOGISTS

NOTICE OF PRIVACY PRACTICES—ACKNOWLEDGEMENT

We at Puget Sound Dermatology are working to ensure that confidentiality regarding your medical information is maintained at all times. We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office manager. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

CONSENT TO LEAVE MESSAGES:

I, _____, give Puget Sound Dermatology (PSD) permission to
Print Patient Name
leave messages regarding my medical care, tests or lab results on answering machine or with an individual at the following number:

□ Yes: Preferred Phone #: _____

□ No Messages – I understand that it is my responsibility to call PSD to receive test results and that I will not receive appointments reminders

Here is a list of the people authorized to receive information about my healthcare:

_____ _____
Name Relationship

_____ _____
Name Relationship

APPOINTMENT REMINDERS:

I would prefer to receive appointment reminders via (*please select one*):

□ Phone: _____

□ Email: _____

□ Text Message Cell #: _____Please text psderm to 622622 to set up

EMERGENCY CONTACT:

First _____ M. Initial _____ Last _____

Relationship to Patient: _____ Phone _____

By my signature below I acknowledge receipt/review of the notice of Privacy Practices.

SIGNED _____ DATE _____
Patient, Parent or Legal Guardian

_____ _____
Printed Name if signed on behalf of patient Relationship (parent, guardian, personal representative)

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