Puget Sound Dermatology, PLLC

21701 76th Ave W, Suite 302, Edmonds, WA 98026-7536

NOTICE OF PRIVACY PRACTICES—ACKNOWLEDGEMENT

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 MESSAGE

We at Puget Sound Dermatology, PLLC are working to ensure that confidentiality regarding your medical information and care is maintained at all times. Because of these confidentiality concerns, we need your signature to allow us to leave a message about your medical care/procedure with someone in your household or on an answering machine.

Please complete this form and indicate your preference.

I, ______________________________, give Puget Sound Dermatology, PLLC permission to:
Print Patient Name

Leave a message regarding my medical care/procedure on answering machine or with an individual at the following number(s):

☐ No Messages Please

☐ Yes: Home #:______________________ Day #:______________________

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

______________________ ______________________
Name Relationship

______________________ ______________________
Name Relationship

______________________ ______________________
Name Relationship

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)**

Thank you for helping to serve you better.