WOLL DERMATOLOGY: NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that Woll Dermatology has prepared a Notice of Privacy Practices, which informs me how Woll Dermatology uses and discloses my protected health information and what my privacy rights are in regards to that information. I may obtain a copy of the full, detailed Privacy Notice by asking an Woll Dermatology front office employee. By signing below, I also acknowledge that I am aware Woll Dermatology has revised their original Notice of Privacy Practices and that I may request a copy of the revisions.

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Signature and Date

WOLL DERMATOLOGY REQUEST FOR CONFIDENTIAL INFORMATION COMMUNICATION

Woll Dermatology's privacy notice discusses how we may communicate your protected health information to you. We will either mail information to you, attempt to call you, fax information to you, or post information to your patient portal. If you initial or request the fax option, please be aware that your confidential information may be faxed to an unsecure site, i.e. a general fax machine at your home or your office where others may see your information. Please initial the appropriate boxes below informing us how and where we may communicate with you.

MAIL: HOME ______ OFFICE ______ OTHER ______________________________

PHONE: HOME _______ OFFICE ______ CELL ______ OTHER _______________

FAX: HOME_______ OFFICE_______ OTHER____________________________

PATIENT PORTAL: __________________

INFORMATION MAY BE LEFT WITH AND MY CONFIDENTIAL INFORMATION MAY BE SHARED WITH: **<u>* NAMES MUST BE PROVIDED*</u>**

MYSELF ONLY _______________________

HUSBAND/WIFE ____

CHILDREN/WHOM ____

PARENTS/WHOM ____

OTHER ____

I AUTHORIZE WOLL DERMATOLOGY TO RELEASE AND SHARE MY CONFIDENTIAL HEALTH INFORMATION AS INDICATED ABOVE.

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Signature and Date