Wolff Dermatology

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T (518) 350-4694 F (518) 309-6563

Preferred Contacts

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home.

We invite you to share with us your preferred place and manner of communication. **You may update or change this information at any time; *please do so in writing*.**

Patient Name: _____ **Date of Birth:** _____
(Print Clearly)

I prefer to be contacted in the following manner (check all that apply):

- ☐ Home Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Cell Phone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication: _____
  - ☐ OK to mail to my home address
  - ☐ OK to mail to my work/office address
- ☐ Other: _____

Preferred Contacts:
We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with, including information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments.

Please update this information promptly if your preferences change.

Please indicate the person(s) you prefer we share your information with below:

- **Name:** _____ **Telephone:** _____ **Relationship:** _____
- **Name:** _____ **Telephone:** _____ **Relationship:** _____
- **Name:** _____ **Telephone:** _____ **Relationship:** _____

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)