SKIN
DERMATOLOGY

Patient Instructions for Communication Preferences

Patient Name (Please Print): _____

Patient Address: _____

Date of Birth: _____ Last 4 Digits of Social Security # _____

I authorize my doctor or staff to leave messages including certain medical information:

_____ NO, do not leave messages on my answering machine or voice mail. I prefer that my doctor or staff speak to me personally regarding any medical information.

_____ YES, you may leave a message on my answering machine or voice mail, including:

_____ Home _____ Work _____ Cell

_____ YES, you may share information with the following individuals:

_____ Spouse of Significant Other _____

_____ Son or Daughter _____

_____ Any Relative _____

_____ Other _____

This information may include information such as:

_____ Lab Test and X-Ray Results _____ Treatment or Medication Information

_____ Billing Information _____ Prescription Refills Information

_____ Information Regarding Appointments _____ All information, no exceptions

I understand that I may notify the doctor's office at any time of changes to this request, which would require a new form and authorization to be completed.

_____ _____

Signature Date

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