Steven A. Proper, MD, MPH
Board Certified in Dermatology
Board Certified in Endocrinology
Fellowship Trained Mohs Surgery
Fellowship Trained Dermatopatholog

David, B. Sable, MD, Ph.D.
Board Certified in Dermatology
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Debra Shelby, DNP, ARNP, DNC
Raymond Shulstad, MS, ARNP-C, BC
Nicole Bence-Franco, PA-C
Michelle Goff, PA-C
Elizabeth Meredith, PA-C

Designation of Alternative Communications

Patient Name: ____

Address: ____

Date of Birth: ________________________ Today's Date: _______________

As allowed by HIPAA Privacy Regulations, and as an alternative to a face-to-face meeting, I wish for this office to utilize the following means of communicating to me my Protected Health Information (any information regarding your private health):

□ Mailing Address
If appropriate, you may contact my by mail at the following address

____

□ Telephone
If appropriate, you may contact me by telephone at the following number. You may/may not (please circle one) leave my Protected Health Information on the answering machine.

____

□ Fax
If appropriate, you may contact me by fax at the following number:
____

□ E-Mail
If appropriate, you may contact me by e-mail at the following email address:

____

□ I have the following additional requests for confidential communications regarding my Protected Health Information (such as allowing this office to discuss your Protected Health Information with a family member or friend): ______________________________

___________________________________ ________________________
PATIENT SIGNATURE Date

Acknowledgement of Receipt of Notice of Privacy Practices

(to be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

SIGNED: ____Date: __________________________

Relationship (if not signed by patient): ____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): ____

By (name and title): ____