Confidential Communication Request (HIPAA Form)

Your physician and other staff members will at times need to contact you via telephone. By filling out the information below, **West County Dermatology** will be better able to serve you.

*UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, WE WILL NOT:
1) LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT OR LEGAL GUARDIAN.
2) LEAVE INFORMATION ON AN ANSWERING MACHINE OR VOICEMAIL.

Please read below and consider carefully whom you want to have access to your medical information.
I, _____ give **West County Dermatology** my permission to leave phone messages regarding my medical care and test results on my phone numbers listed below and/or with the following individual(s). I fully understand that this consent will remain in effect until revoked in writing.

Please fill out the information and sign below:

Daytime: ( ) _____-_____ Evening: ( ) _____-_____

Cell: ( ) _____-_____

Can leave message? YES or NO

Can speak with:_____ _____
Relationship to Patient

Can speak with:_____ _____
Relationship to Patient

Can speak with:_____ _____
Relationship to Patient

Name (Print): _____

Signature:_____