1001 Chesterfield Parkway East Suite 201
Chesterfield, MO 63017
Office: (636) 532-2422 Fax: (636) 532-2425

NAME: _____ DOB: _____

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF HIPAA PRIVACY PRACTICES

REVISED SEPTEMBER 23, 2013

AUTHORIZATION TO DISCUSS TREATMENT

(1 box must be checked by patient)

☐ I, _____, request the physicians and employees of West County Dermatology to discuss my treatment and test results with no one other than myself.

☐ I, _____, authorize the physicians and employees at West County Dermatology to leave phone messages regarding my medical care and test results on my following phone numbers:

Preferred phone #_____ Alternate phone #_____

☐ I, _____, authorize the physicians and employees of West County Dermatology to discuss my treatment and test results with the following:

PERSON	RELATIONSHIP	PHONE#
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have received a copy of the above mentioned Notices for West County Dermatology AND provide authorization to discuss treatment as indicated above.

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt for the above mentioned Notices; however, acknowledgement could not be obtained because:

( ) Communication barriers prohibited obtaining the acknowledgement.
( ) An emergency situation prevented us from obtaining acknowledgement.
( ) Patient refused to sign.
( ) Other (Please Specify): _____