Goldstein
Dermatology & Medical Laser Center

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Notice of Privacy Practices-Patient Acknowledgement
Phone Message Consent Form

Patient Name:_____

Date of Birth:_____

I have read/received this practice's Notice of Privacy Practices written in plain language. This Notice provides in detail the uses and disclosures of my protected health Information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health Information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy practices on request.

We may contact you by phone or in writing to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

I wish to be contacted in the following manner:

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE:_____

LEAVE A DETAILED VOICE MAIL MESSAGE? YES NO

LEAVE A MESSAGE WITH A CALL BACK NUMBER? YES NO

_____ _____
Signature of Patient/Authorized Representative Date

By signing this consent, I give permission to the person(s) listed below to receive information, including phone messages about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/-friend in order to assist with my continuing care. This permission will be considered ongoing until I state in writing otherwise.

_____ _____
Name of Individual & Relationship Date

_____ _____
Signature of Patient/Authorized Representative Date