DERMATOLOGY PARTNERS OF WNY, LLP
HIPAA CONSENT

PATIENT NAME: _____ DATE OF BIRTH: _____

By law, we may not contact you with protected medical information without your consent. However, there are many instances where we may need to reach you to discuss such information, as with appointment reminders or test results. Please let us know how we can best contact you.

CONTACT INFORMATION

I give consent to contact me by:

☐ Cell Phone Permission to leave a message? ☐ Yes ☐ No

☐ Texting (If available)

☐ Home Phone Permission to leave a message? ☐ Yes ☐ No

☐ Work Phone Permission to leave a message? ☐ Yes ☐ No

In the event that we cannot reach you via telephone, test results may be sent by mail.

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP: _____

TELEPHONE: _____

X_____ DATE:_____/_____/_____

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE

LAST UPDATED: 04/06/17