PATIENT PRIVACY QUESTIONAIRE
HIPAA ACKNOWLEDGEMENT
PRESCRIPTION MEDICATION REQUEST CONSENT

Name: _____ Date: _____

You may be contacted by us to remind you of appointments or discuss healthcare treatment options, results, or other health-related matters.

Please list any preferred phone numbers:

Home: _____ Cell: _____

Work: _____ Other: _____

Can we leave a message at the above numbers? ___ Yes ___ No

Are there any restrictions with regard to our office contacting you with medical information?

_____

_____

Would you like to authorize an individual(s) as your personal representative? This person would have the authority to schedule, confirm or change appointments only. ___ Yes ___ No ___ N/A If yes, please list full names:

_____ _____

I agree that my prescription medication history may be requested from other healthcare providers or third party pharmacy benefit payors and used for treatment purposes.

_____ _____

Patient or Personal Representative Signature Date

SelectSKinMD has offered me a copy of my rights as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

_____ _____

Patient or Personal Representative Signature Date