JENNIFER W. PENNOYER, M.D.
Medical & Surgical Dermatology
Laser & Cosmetic Skin Care

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HIPAA PATIENT COMMUNICATION FORM

It is the office policy of Pennoyer MD Dermatology not to release confidential medical information regarding your treatment to family members or friends, except for parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room., we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1998 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below.

By signing below, you authorize the following people to receive information regarding your treatment:

List names (please list relationships such as spouse, parent, boyfriend, girlfriend, sister, brother, etc.)

_____

_____

If you wish to add names later on, please confirm in writing or call our staff directly.

How may we contact you? ***(PLEASE WRITE IN NUMBER)***

Home phone_____ Cell Phone_____ Work Phone_____

___ DO NOT leave a message	___ DO NOT leave a message	___ DO NOT leave a message
___ OK to leave a message	___ OK to leave a message	___ OK to leave a message
___ Use as primary number	___ Use as primary number	___ Use as primary number

Patient's Printed Name:_____Patient's DOB:_____

Patient's Signature:_____

Parent/Guardian's Printed Name:_____

Parent/Guardian Signature:_____Todays Date:_____