COMMUNICATION CONSENT

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, a federal law. The Department of Health & Human Services has developed specific regulations designed to protect the privacy of your health information.

Automated Appointment Reminders
Our office uses an automated telephone appointment reminder system. Prior to each appointment, a phone call will be placed to your home number. An automated reminder message will be played for whoever answers your home phone. In the event that the call is picked up by an answering machine or voice mail, the message will be recorded. This message will state your name, the name of the provider you will see and the date and time of your appointment. To protect your confidentiality, this message will NOT include the reason for your visit or the name of our practice.

Personally Dialed Calls
It will be the policy of Dermatology Associates of York, Inc., to only release confidential medical information to the patient or an authorized representative of the patient as listed below, (unless release is further allowed by law). In the event that we encounter an answering machine, voice mail or an unauthorized person when placing a call, our message will be limited to the patient's name, the name of our practice and/or the provider you see, our phone number and a request for the patient to return a call to our office.

Permission to Leave Message on: (*Check box if OK*)

Answering Machine/Home Voice Mail? . . . . . ❑
Work Voice Mail? . . . . . ❑
With Another Person? . . . . . ❑
Send through mail? . . . . . ❑
Send via e-mail? . . . . . ❑
Cell Phone? . . . . . ❑

Authorized Contact(s)	Relationship	Contact Phone #

I authorize Dermatology Associates of York to contact and/or leave messages relating to my care, or related to payment for my care, by the above methods and will assume responsibility to notify Dermatology Associates of York whenever this information changes.

Patient's Name:_____ Chart#_____
(*please print name*)

_____ Date:_____
Signature Of Patient Or Patient's Representative

INITIAL / DATE
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