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MODERN DERMATOLOGY

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CONFIDENTIAL COMMUNICATION REQUEST

Please read the following choices and tell us whether or not we can leave voice mail regarding your medical information, such as lab & test results, and with whom we may leave it. Please choose one of the following:

I DO CONSENT Modern Dermatology to leave detailed messages:

I, _____ give Modern Dermatology staff permission to leave telephone messages regarding my medical care with the following options: (Initial each one that you want us to be able to use for leaving you telephone messages). This will remain in effect until you rescind it in writing.

❐ Answering machine _____Initials _____

❐ My cell phone _____Initials _____

❐ Email_____Initials _____

❐ Spouse (name) _____

Phone number(s) _____Initials _____

❐ Other (name) _____

Phone number(s) _____Initials _____

❐ Other (name) _____

Phone number(s) _____Initials _____

Signature _____Date _____

I DO NOT CONSENT to leave detailed messages on my phone or answering machine or with any member of my family.

Signature _____Date _____

If not signed by patient, please indicate your relationship to the patient _____

Print Patient Name: _____ Date of Birth _____

_____I do NOT wish to receive email promotions about events and special offers from Modern Dermatology.