Braddock Finnegan Helget Dermatology, P.C.

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www.braddockfinneganhelget.com

Privacy Notice Acknowledgement

Patient Name:_____ Date of Birth: ____/____/_____

I have received or was offered the Braddock Finnegan Helget Dermatology, P.C. Notice of Privacy Practices. *(Note: My signature does not indicate that I have read, understood, or agree with the Notice, only that it has been provided or offered to me.)*

HIPAA

(Health Insurance Portability and Accountability)

This section is to give Braddock Finnegan Helget Dermatology, P.C. permission to contact/disclose my health information to the following persons:

Name:_____ Telephone:_____ Relationship:_____

Name:_____ Telephone:_____ Relationship:_____

Name:_____ Telephone:_____ Relationship:_____

Tell us how we may contact you: (check all that apply)

- ☐ Home/Cell#:_____
- ☐ Work#:_____
- ☐ Leave a message: Appointment Date and Time
- ☐ Ok to leave a detailed message including normal test results.
- ☐ Do not leave a voicemail message.

X_____ _____

Signature of Patient/Legal Guardian Date