# Bay Area Skin Cancer Surgery and Dermatology

## PATIENT COMMUNICATION FORM

Family and Friends. It is the office policy of Bay Area Skin Cancer Surgery not to release medical information regarding your treatment to family members or friends except for 1) parent/legal guardian, 2) other people authorized by the patient, 3) as we may reasonably infer from the circumstances (for example, if you bring a family member of friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), 4) in emergency situations, or 5) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

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 checking the line next to the "yes" response, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add or delete names later on, those changes must be confirmed in writing by filling out a new communication form.

Spouse: _____ _____ Yes _____No

Parent: _____ _____ Yes _____No

Other: _____ _____ Yes _____No

Means of Communication. Please indicate the means in which we are permitted to communicate with you:

Home phone _____ Yes _____ No

Cell phone _____ Yes _____ No

Mail _____ Yes _____ No

Email _____ Yes _____ No

Alternative Communication. You are also entitled to specify alternative reasonable means of communication, if you do not wish to be contacted with us in a certain way.
Other alternative methods requested: _____

**PRINTED NAME**: _____

**Patient/Parent/Guardian Signature**:_____

Date: _____