Total Dermatology Care Center

Request for Confidential Communications

I, _____ authorize the staff of Total Dermatology Care Center to notify me of my diagnostic or lab results. Please check one or more of the options:

_____ Speak with me only

_____ Leave a message at my phone number designated below if I am not available

_____ (Patient's Initials)

Home (_____) _____

Work (_____) _____

Cell (_____) _____

_____ Leave a message with anyone answering my phone.

_____ Name of other person(s) authorized to accept results for me:

_____
Name

_____
Relationship

Telephone ( )

_____ Other

_____ **Don't call me with any results.** I will call the office if I want test results.

Complete address for communication

Local _____
_____
_____

Permanent _____
_____
_____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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