Karimipour Dermatology
Darius J. Karimipour M.D., P.C.

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Darius J. Karimipour, M.D., P.C. not to release confidential medical information regarding your treatment to family members or friends, *except* for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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, so that we may best serve you. If you do not want any of your medical information provided to a family member, please mark appropriately below. By signing below, you authorize the following people to receive information regarding your treatment or care. You are entitled to receive a copy of this form at any time, and can request a new copy if any changes are made.

***If you wish to make changes to this form in the future please confirm this in writing, or call our staff.*

Spouse: ________________________________ ______ YES ______ DECLINE

Parent: ________________________________ ______ YES ______ DECLINE
Other:_________________________________ ______ YES ______ DECLINE

________________________________ ______ YES ______ DECLINE

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us by phone.

Best Contact Method:_____________________________

PATIENT NAME (please print) ______________________________

Patient/Legal Guardian Signature:____________________________ Date: ___________

Witness Signature: ____ Date: ____________

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FOR OFFICE USE ONLY
Changes to above that were authorized by patient via phone:

Change Made	Date	Staff Initials
____	_______	______
____	_______	______
____	_______	______