LIMMER DERMATOLOGY
Your Skin. Our Specialty.

ACKNOWLEDGEMENT OF HIPAA FORM

I acknowledge I have read the HIPAA Notice of Byron L. Limmer, M.D. & Rachel L. Limmer, M.D., P.A. and below are listed family members and/or friends with whom it is permissible to share my PHI (Protected Healthcare Information). This authorization will stay in affect unless it is changed by me.

Name of Person(s) Who May Receive My Medical Information

Name	Relationship	Phone Number

In general, the HIPAA privacy act gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternate means, such as sending correspondence to the individual's office instead of the individual's home. I wish to be communicated in the following manner:

Telephone	Yes	No		Written Communication	Yes	No
Leave detailed message at home				Ok to mail to my home		
Leave call back number at home				Ok to fax to this number Fax#:_____		
Leave detailed message at work				Ok to mail to my work/office		
Leave detailed message on cell phone						

☐ **No Restrictions Requested**

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(Print Name) Patient or Responsible Party (Signature) (Date)