

The notice of privacy practice for Illinois Dermatology Institute, LLC office is available at the front desk and on our website at www.idi-skokie.com. Should you wish to receive your own copy to take with you please ask our receptionist. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at your next visit, call our office and request a copy, or mail a written request.

Section 1 of this document provides your acknowledgement that you have read our Notice of Privacy Practices.

Section 2 requests your response to notification format and designation of a family member or other designee that we may contact and discuss your medical care in the event of an emergency or for the purpose of the individual items as checked below.

Section 3 provides the opportunity to opt in or opt out of receiving marketing communication from our office.

Section 1 - Acknowledgement

I acknowledge and understand the Notice of Privacy Practices for the office Illinois Dermatology Institute, LLC

Patient Name

Date

Date of Birth

MRN (office use)

Section 2 - Notification and Emergency Designee

I give permission to Illinois Dermatology Institute, LLC (IDI) and staff to perform the following duties in an effort to maintain continuity of care.

Confirm/revise my appointment times by calling my home, business, and any other designated phone number.

YES NO

How would you like to receive your courtesy appointment reminders? (Please choose only one):

Email _____ Text _____ Phone call _____

Leave a message of normal test results on my phone or with a specified family member.

YES NO

The office and personnel are authorized to contact the party below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointments and test results:

Designated Person

Contact Number

Section 3 - Marketing communication.

IDI would like to share new product, discounts or service information directly to you, our patient. The information may be communicated by letter, or email. (You can change your decision at any time by notifying our office or by selecting unsubscribe on electronic communications.)

I wish to opt IN Email Address _____

I understand the information provided to me in the privacy notice and I have indicated my response to questions in each section.

Patient Signature and Phone number

Date