## Aesthetica Cosmetic and Laser Surgery Center 1342 Chelsea Ave., Rear

## **PATIENT COMMUNICATION FORM**

PRINTED NAME:	DATE:	
A. <u>Family and Friends</u> . It is the office policy of Aesthetic P.C. not to release confidential medical information regardients or friends, except for (i) parent/legal guardian patient, (iii) as we may reasonably infer from the circum family member or friend into the exam room, we will as person is entitled to receive information regarding your situations, or (v) other as otherwise permitted by the Heacountability Act of 1996 (HIPAA).	arding your treatment in a comment in a comm	to family horized by the f you bring a ct, that the ergency
If you anticipate that you will need or want your medical info friends, or caretakers/babysitters, please indicate that below not want any of your medical information provided to a fami to the "no" response. By signing below, you authorize the fol regarding your treatment or care. (If you wish to add names I call our staff.)	, so that we may best ser ly member, please check lowing people to receive	eve you. If you do $(\sqrt{\ })$ the line next information
Spouse:	Yes	No
Parent:	Yes	No
Other:	Yes	No
B. <u>Alternative Communications.</u> You are also entitled to specify alternative, reasonable means of communications, if you do not wish to be contacted by us in a certain way.  I hereby request the following means of contact only: By Home Phone  By Mobile Phone By Business Phone		
PATIENT/PARENT/GUARDIAN SIGNATURE:		