Sandra Read, MD
Dermatology

TO MY PATIENTS:

In order to protect your privacy, I would appreciate it if you would assist me in filling out the following information regarding how to transmit medical information to you.
It is often necessary to notify patients regarding appointments, medical information, billing questions, or other important information.

May I, or my office staff, notify you by telephone?

YES _____ **NO** _____

If so, what telephone numbers would you like for us to use?

Office#: _____

Home#: _____

Cellular#: _____

May we leave detailed messages at this number? Information relayed would be the name of the office, the reason for the call, and/or recommedations?

YES _____ **NO** _____

Is there any other information that you would like to related as to how to protect your privacy?

Please sign your name: _____
Date: _____

THANK YOU

2021 K STREET, NW
SUITE #508
WASHINGTON, DC 20006
(202) 223-6830 - work #
(202) 223-6833 - fax #

Sandra Read, MD

NOTICE OF PRIVACY PRACTICES

Under HIPPA legislation, I am required to provide the following information and ask you to sign that you received and have read the following:

Thank you for your time and understanding.

This explains how your medical information may be used and disclosed by us and how you may gain access to your medical information.

USES AND DISCLOSURES

As explained in our complete private notice, we may use and share health information about you:

- **for treatment, payment, and business and administrative activities,**
- **to inform you about our health-related products and services,**
- **to recommend other treatments and health care providers,**
  for medical research and public health activities.

For other proposed uses or disclosures, except as required by law, we will explain
the use or disclosure and seek your permission.

YOUR RIGHTS AND CHOICES

You may:

- **review, copy and ask us to amend certain health information we have about you,**
- **ask us for a list of certain disclosures we have made that information,**
- **ask us to deliver health information about you to an alternative address,**
  ask us not to share your health information with certain family members or friends

Where you have given us permission to use or share your health information, you may change
your mind at any time. To exercise these rights or choices, contact us as indicated below.

Please sign & date:

_____