PETER A. DABROWSKI, MD
Diplomate Board of Internal Medicine

I wish to be contacted in the following manner (check all that apply)

_____ I have no preferences and the office may call any number/email and leave any messages

Home Telephone
_____ Okay to leave message with detailed information
_____ Cell Phone Okay to leave messages
_____ Leave message with call back number only

Work Telephone
_____ Okay to leave message with detailed information
_____ Leave message with call back number only

Written Communication
_____ Okay to mail to home address
_____ Okay to mail to office/work
_____ Okay to fax to this number: _____
_____ Okay to email communication _____

I agree that *Peter A. Dabrowski, MD* may disclosed certain health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, *Peter A. Dabrowski, MD* will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.
I designate the persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of Peter A. Dabrowski, MD making the limited disclosures described above. I understand that I am not required to list anyone and that I may change this list at any time in writing.

Name:_____ Relation:_____

Name:_____ Relation:_____

This information is correct and complete to the best of my knowledge. I acknowledge that I have received, read, and agree with the Notice of Privacy Practices, version effective April 14, 2003. I have been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my individually identifiable health information, or to request additional confidential treatment of communications between the Practice and myself or others. Also by signing below, I acknowledge that any areas no filled in the above sections regarding privacy matters means that I do not have any specific concerns regarding the means of communication of my health care information.

Signed_____ DATE:_____