Dermatology Consultants of South Florida, PA

PATIENT NO.
DATE

PERMISSION TO CONTACT YOU and CONSENT TO RELEASE MEDICAL RECORDS

Patient's rights of disclosures: The HIPAA privacy rule gives an individual the right to request restrictions on uses and disclosure of health information (PHI). The individual also has the right to request the confidential communications of health information (PHI) be made by alternative means.

PERMISSION TO CONTACT YOU

CONTACT INFORMATION:

I, (PRINT PATIENT NAME): _____ , wish to be contacted in the following manner:

Please *initial* ALL statements below that apply to you:

My Preferred Phone Number: _____

____ OK for Dermatology Consultants to leave a detailed message at my preferred phone number OR

____ OK for Dermatology Consultants to call preferred phone number but ONLY to leave a message to call the office.

____ OK for Dermatology Consultants to text a detailed message to my cell phone (preferred number).

Written communication

____ OK to mail to my home

____ OK to fax to my home _____ Fax Number

____ OK to fax to my work _____ Fax Number

Email* to the following email address: _____

____ OK to email my biopsy/lab results or a detailed message

____ OK to email only to advise me to contact the Dermatology office

*Any medical information sent via unsecured email is inherently not secure and could result in the information being accessed while in transit.

CONSENT TO RELEASE MEDICAL RECORDS

Please fill out the information below so we may send you, or those you specifically designate, your protected health information (your health records) upon your request. My signature below gives Dermatology Consultants permission to inspect and copy such records.

List all persons who, in your absence, may make requests on your behalf, and with whom we may speak regarding your medical information.

Name	Relationship
_____	_____
_____	_____
_____	_____

Please initial the following:

____ The information and authorizations on this form shall remain in effect, and Dermatology Consultants of So FL may rely upon them in all respects, unless you have previously been advised by me in writing to the contrary. It is expressly understood by the undersigned, that you are hereby authorized to accept a copy or photocopy of this medical authorization with the same validity as though an original had been presented to you.

Patient Signature:_____ Date: _____

****FOR FASTEST SERVICE: Your patient records including your biopsy and lab results are available on your PORTAL.**