DERMATOLOGY ASSOCIATES, P.A.

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Receipt of Privacy Practices; Consent for Use / Disclosure of Protected Health Information (PHI)

I, _____, _____ was provided a copy of
(name) (date of birth)

Dermatology Associates, P.A.'s Privacy Practices Notification. Dermatology Associates may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize Dermatology Associates to use or disclose my PHI in conjunction with Dermatology Associates treatment, payment or healthcare operations in accordance with the terms of this consent.

_____ _____
Signature of Patient/Guardian Date

Further I hereby authorize and give my consent to Dermatology Associates, P.A. to leave messages on my answering machine / voicemail for the following (check all that apply)

Appointment Reminders	____	Prescription Refills	____
Medical Information	____	Test Results	____
		Mail	____

I further authorize and give consent to Dermatology Associates, P.A. to communicate any of my PHI to the following persons:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Signature of Patient / Guardian Date