UNIVERSITY DERMATOLOGY
COMMUNICATION & ACKNOWLEDGMENT FORM

Patient's name:____ Date of Birth:__________
please print

University Dermatology is not permitted, by law, to provide medical information to anyone other than the patient except for treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

The staff at University Dermatology would like to know with whom, if anyone, you want us to be able to discuss your treatment, treatment plans, condition updates, lab results, appointment information, billing information, or picking up of samples. This would also include leaving messages on your answering machine or in your voicemail box. If you would also like us to communicate with you by e-mail to address your health information or for specials, promotions, or other office events, please indicate so below.

Please complete the following so that the individuals you specify can have access to your information as described above.

I, ____________________________, as a patient of University Dermatology, authorize the release of my medical information regarding my treatment and care to the following individuals upon their request:

____ __________ ________________ ________________
Name *(please print)* Date of Birth Relationship Phone Number

____ __________ ________________ ________________
Name *(please print)* Date of Birth Relationship Phone Number

______________________________________ __________
Signature of Patient/ Authorized Representative Date

E-mail: I, ____________________________, authorize University Dermatology to e-mail me information regarding my care or for specials, promotions, or other office events that may become available. I understand that my e-mail address will be kept confidential in the same manner as all my other health related information.

____
(e-mail address at which I wish to be contacted)

By signing below I authorize University Dermatology to communicate protected health information to me as described above. I further acknowledge that I have been given the opportunity to read the Notice of Privacy Practices for University Dermatology describing how my protected health information may be used and disclosed as permitted under federal and state law. I understand that I may obtain a complete copy of the Notice for my records upon request at any time.

Please Print Name:______________________________________

Signature:____ Date:_______________
(Patient or Authorized Representative)

Relationship to Patient (If person other than patient signing this form):____________________________

________________________________**For Office Use Only**______________________________

Reason Patient unable/unwilling to sign:____

____
rev. 9/09