AFFILIATED DERMATOLOGISTS & DERMATOLOGIC SURGEONS, P.A.

Communications Regarding Protected Health Information (PHI)

Patient Name:_____D.O.B. _____ Date: _____

Authorized Individuals

I understand that Affiliated Dermatologists & Dermatologic Surgeons, P.A. (the "Covered Entity") may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "yes" below may be released:

Name: _____ Relationship: _____

Address/Phone: _____

Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Name: _____ Relationship: _____

Address/Phone: _____

Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Name: _____ Relationship: _____

Address/Phone: _____

Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Name: _____ Relationship: _____

Address/Phone: _____

Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Contact Information

I wish to be contacted in the following manner and authorize Affiliated Dermatologists & Dermatologic Surgeons, P.A. to leave a detailed message with my Protected Health Information (Please check all that apply):

☐ Cell Telephone ☐ Home Telephone ☐ Work Telephone ☐ Patient Portal

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DO NOT leave a detailed message with PHI on the following (please check all that apply):

☐ Cell Telephone ☐ Home Telephone ☐ Work Telephone ☐ Patient Portal

**If you check "Do not leave a detailed message with PHI" we will leave only a message to return the call or a message confirming an appointment with no detailed health information.*