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

May we contact you and leave a detailed message with your Protected Health Information at your:

YES ☐ NO ☐ Home Telephone Number

YES ☐ NO ☐ Cell Phone Number

YES ☐ NO ☐ Work Phone Number

YES ☐ NO ☐ Patient Portal

Please indicate YES or NO to all four contact options

**If you check "NO" we will leave only a message to return the call or a message confirming an appointment with no detailed health information.*