



PRIVACY PRACTICES

Dermatology and Oculoplastic Consultants

Name (printed) _____

Notice of Privacy Practices

I acknowledge that I have received a copy of Dermatology and Oculoplastic Consultants' (partnered with Dermatology Associates, PA of the Palm Beaches) **Notice of Privacy Practices** and understand its implications.

_____ / ____ / ____
Patient or Personal Representative Signature Date

*If other than patient signature, please print your name, patient's name, and relationship.

Disclosure to Other Persons Regarding Your Health Information

This Practice may disclose personal health information (test results, biopsy results, billing information and treatment) about you to your family, close personal friends or any person that you identify.

_____ I authorize my personal health information to be disclosed to
Persons I authorize for disclosure: (Please list specific names)

First name	Last name	Relationship to patient

_____ I do NOT authorize my personal health information to be disclosed to a family member, friend or another individual involved in my care.

Releasal of Information Regarding Your Health Information

_____ I authorize DOCs to fax information to me
Fax Number _____

_____ I authorize DOCs to leave my personal health information on my home / mobile voicemail
Preferred Number _____

_____ I do NOT authorize DOCS to leave my personal health information on my cellular phone or answering machine and prefer them to leave the office name and number only

I understand that I may revoke this authorization at any time except to the extent that Dermatology and Oculoplastic Consultants has already relied on this authorization. I understand that I have to provide a written request for revocation stating my intent to revoke the prior authorization.

Signature _____ Print _____

Date ____ / ____ / ____