PRIVACY PRACTICES ACKNOWLEDGMENT & AUTHORIZATION(S)

Dermatology of Coastal Sarasota

Patient's Name (printed): ____

Relationship to Patient: ___ Self ___ Parent ___ Legal Guardian or Representative

If a Parent / Guardian, print name: ____

Authorized Contact Information

I authorize DOCs to communicate the patient's personal health information to me in the following manner:

Phone: ____

Email: ____

Fax: ____

Acknowledgment of Privacy Practices

By signing below, I acknowledge that I have been offered and reviewed to my satisfaction a copy of the **Notice of Privacy Practices** of Dermatology of Coastal Sarasota (DOCs); that I have asked any questions I had and received satisfactory answers; and that I understand it and the authorizations below.

Authorization to Disclose Patient's Personal Health Information to Other Persons

I authorize DOCs to communicate personal health information (such as test results, biopsy results, billing information and treatments) to the specific persons listed below, in addition to the disclosures allowed by law: (Please list specific names, or else leave blank or write "none.") Please be aware that the information disclosed may be re-disclosed or used, and no longer protected under the privacy rules.

First name	Last name	Relationship to patient	Phone

First name	Last name	Relationship to patient	Phone

Additional Authorizations (Please Initial)

_______ I authorize DOCs to send appointment reminders to my contact information above, including text messaging.
(Unless authorized, then DOCs will only leave a phone message with our name and office phone number.)

_______ I authorize DOCs to send information on alternative treatments, services, products, and events of DOCs to my contact information above.

Approval & Signature

These authorizations do not expire unless amended or revoked in writing. I understand that I may amend or revoke these authorizations at any time by giving a written request to DOCs, except as DOCs has already relied upon any prior authorizations given or as DOCs is otherwise permitted by law.

____ ____________________

Signature of Patient / Parent / Guardian / Representative Date