

New Age Dermatology, P.A.

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DESIGNATED INDIVIDUALS AUTHORIZATION FORM / PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

About this form: This form is to help us in managing your care. Please list below any person (such as a spouse, parent, etc.) that we may release your confidential medical record and / or financial account information pertaining to this practice. In addition, in the event that we are unable to reach you directly by phone, and you would like to request your confidential protected health information be left on a personal voice message system, please indicate the phone number(s) that provide access to the voice message system(s) of your choice (Home answering machine, Work voice mail, Cell phone voicemail).

In signing this agreement, I hereby authorize the staff of New Age Dermatology, P.A. to release any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment for services received at New Age Dermatology, P.A. to one or all of the designated parties below. I understand that the identity of the designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Health Insurance Carrier may receive information if we have filed the claim for you.

Yes ___ No ___ If no, please specify restrictions _____

Any restrictions on means of communication? Yes _____ No _____

Confidential information may be left on voice mail at the following number(s):

(____) _____ (____) _____

Any restriction on use and disclosure of medical information? Yes _____ No _____

Brief summary of restrictions: _____

Patient Name _____ Date _____

Patient Signature _____