Consent for Treatment and Release of Medical Information

I authorize treatment and/or services to myself or minor child at Dermatology Associates of South Jersey, LLC. I authorize Dermatology Associates of South Jersey, LLC, to release information requested by my insurance company or any of its agents. I also authorize Dermatology Associates of South Jersey, LLC, to furnish my primary care physician, referring physician or other treating medical professional, any and all information that may be requested regarding my physical or mental condition and treatment rendered; and if necessary, to allow them or any physician appointed by them to examine any records or results regarding my treatment.

This authorization shall remain in force until revoked in writing by the undersigned.
Signed (patient or responsible party):_____ Date:_____
(If minor or other responsible party signs)

Staff member witness: Name_____ Signed_____

Consent for Communication of Information

In addition to release of information as authorized in the Authorization to Release Medical Records and in the interest of confidentiality, and compliance with HIPAA (Health Insurance Portability and Accountability Act), your careful consideration and acknowledgement as to whom we may release information on your behalf is required.
I authorize the release of information as it pertains to my care only to the following individuals:

Name:_____ Relationship:_____ Tel#_____

Name:_____ Relationship:_____ Tel#_____

For the purposes of communicating test results, prescription refill requests, and other protected health information, I authorize my physician and/ or his/her designee to utilize the following mechanism/s:

- ☐ On my home answering machine (#_____)
- ☐ On my cell phone message system (#_____)
- ☐ On my office voice mail (#_____)
- ☐ Via email (email address_____)

(For security and privacy reasons, your physician will not respond to unsolicited email communications)

I have the right to revoke and change my consent options as listed above. When circumstances change regarding my response, I will submit written changes, revocation, limitations, and restrictions to the Dermatology Associates of South Jersey, LLC, at the current address. Your physician and Dermatology Associates of South Jersey, LLC, will not be held liable for communication of protected health information via the consented option(s) above without an updated written consent form.

Signed:_____ Date:_____

Internal Use Only:If the patient or patient's representative refused to sign any of the above acknowledgment, please document the date and time the patient was presented with the above material and sign below:

Information presented on (date)_____ Time:_____
Staff Name:_____ Signature:_____
_____

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of **Dermatology Associates of South Jersey, LLC's** Notice of Privacy Policies (effective date May 1, 2011) detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction (if any) concerning the use of my personal information: