Patient Notice of Privacy
And Disclosure of Health Information

I understand that as a part of my healthcare, Brandon Dermatology and its physician(s) originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that as part of this organization's treatment, payment, and health care operations, it may become necessary to disclose my protected health information to another entity associated with my medical care. I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

The complete Privacy Policy Notice of Brandon Dermatology and its physician(s) is available in the office for my perusal. I may also request my own copy if I desire.

I fully understand and accept the terms of this consent.

Patient Name (print)________________________________ Date___________________

Patient Signature__________________________________

Parent or Authorized representative (if applicable)____

Please complete the following information:

Name of person(s) with whom we may discuss your medical information (i.e. wife/husband, child, etc)

Name__________________________________ Relation_____________________________

Name__________________________________ Relation_____________________________

Name__________________________________ Relation_____________________________

May we leave a message about the following:

Upcoming scheduled appointments ☐ yes ☐ no

Normal laboratory/pathology results ☐ yes ☐ no