REN

DERMATOLOGY

HIPAA AUTHORIZATION FOR COMMUNICATION OF MEDICAL INFORMATION

The patient or patient's legal representative signing this form ("Patient") hereby authorizes REN Dermatology ("Provider") to communicate about Patient's medical information with Patient and/or others as stated below:

PATIENT

Patient Name: _____ **Date of Birth:** _____ /_____ /_____

Parent/Legal Representative: _____ **Relationship to Patient**: _____

Address: _____

PREFERRED CONTACT METHOD

Provider may contact Patient by:

Calling: (_____) _____-_____ □ Cell phone □ Home phone □ Work phone

Texting: (_____) _____-_____

Emailing: _____

If Provider cannot reach Patient *(check one)*:

☐ Provider ***MAY NOT*** leave voice messages.

☐ Provider may leave a detailed message on preferred contact method (regarding pathology, scheduling, etc.).

☐ Provider may leave a voicemail only asking Patient to return Provider's call.

COMMUNICATION WITH PERSON OTHER THAN PATIENT

(Check one):

☐ **Patient does not want to designate someone who Provider may communicate with about Patient's medical information. (*if you check this box, please skip to the signature box on the back of this page*)**

☐ **Patient authorizes Provider to communicate with the following person ("Designee") about Patient's medical information *(check all that apply)*:**

☐ **Spouse**: _____ **Phone Number:** (_____) _____-_____

☐ **Child**: _____ **Phone Number:** (_____) _____-_____

☐ **Other**: _____ **Phone Number:** (_____) _____-_____

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MEDICAL INFORMATION THAT MAY BE COMMUNICATED

Patient authorizes Provider to communicate with Designee only about the following medical information *(check all that apply)*:

☐ All medical information.

☐ Medical information regarding a specific date of service: (date) _____.

☐ Medical information regarding a range of dates of service: from (date) _____ to (date) _____.

☐ Medical information limited to: _____.

☐ All billing information.

This authorization includes medical information on diagnosis or treatment related to *(initial all that apply)*:

(initial) _____ psychiatric or psychological conditions.

(initial) _____ drug or alcohol abuse

(initial) _____ acquired immune deficiency syndrome (AIDS) or HIV status.

PURPOSE OF COMMUNICATION

Patient authorizes Provider to communicate with Designee about Patient's medical information for the following purpose(s) *(check all that apply)*:

☐ Patient Care ☐ Billing ☐ Other (specify) _____.

ACKNOWLEDGEMENTS

Patient acknowledges that:

- Patient may refuse to sign this authorization.
- Refusing to sign this authorization will not affect Patient's treatment, payment, enrollment, or eligibility of benefits.
- Patient may take back (revoke) this authorization in writing, except for any actions already taken based upon it.
- If the person requesting or receiving Patient's medical information is not a health plan or health care provider, the released medical information may no longer be protected by federal privacy rules and may be shared with others.
- Patient will receive a copy of this form after Patient signs it.
- **This authorization will remain in effect for 12 months unless revoked in writing.**
- **This authorization will expire 12 months after the date Patient signs it.**

SIGNATURE

By signing this authorization below, Patient makes the authorizations and acknowledgements stated above.

Signature of Patient/Legal Representative: _____ **Date:** _____

Relationship to Patient: _____