Franklin Dermatology Group

HIPAA AUTHORIZATION

Patient Name: _____ DOB: _____/_____/_____

CHOOSE ONE:

☐ **I DO NOT authorize Franklin Dermatology Group to release my medical and billing information to anyone other than myself.**

OR

☐ **I authorize Franklin Dermatology Group to release my medical and billing information to the individuals listed below:**

RELATIONSHIP		NAME OF DESIGNATED PERSON	PHONE
SPOUSE	☐ YES ☐ NO	_____ Please Print	_____
CHILDREN	☐ YES ☐ NO	_____ Please Print	_____
IN-LAWS	☐ YES ☐ NO	_____ Please Print	_____
CAREGIVERS	☐ YES ☐ NO	_____ Please Print	_____
PARENTS	☐ YES ☐ NO	_____ Please Print	_____
OTHERS:		_____ Please Print	_____

I authorize Franklin Dermatology Group to leave information on my voicemail:

HOME: ☐ YES ☐ NO CELL: ☐ YES ☐ NO WORK: ☐ YES ☐ NO

The HIPAA privacy rule permits health care providers to communicate with patients regarding their health care, including protected health information (PHI) and billing information. This includes communicating with the patient through mail, phone, fax or some other manner.

I understand that FDG is permitted by the HIPAA privacy rule to leave information regarding my appointment, including, the date and time, on any phone number(s) provided. FDG may request a return phone call to our office by leaving a message or when speaking to any individual that answers the phone. If I only want confidential communication between myself and FDG I must provide written notice to FDG on a form provided upon my request.

I understand that it is my responsibility to keep FDG informed of any changes to this information and that I may revoke this authorization at any time by written notice to FDG on a form provided upon my request.

_____ _____

Signature of Patient or Personal Representative (Legal Guardian) Date

_____ _____

MINOR Patient ONLY - Print Name of Personal Representative (Legal Guardian) Date