# ESTERSON DERMATOLOGY

## HIPAA Communication Form

Patient Name:_____ Date:_____

**Please tell us how you wish to be contacted. Check all that apply.**

Home Phone __YES __NO __Leave message with detailed information

( )_____-_____ __Leave message with call back number only

Work Phone __YES __NO __Leave message with detailed information

( )_____-_____ __Leave message with call back number only

Cell Phone __YES __NO __Leave message with detailed information

( )_____-_____ __Leave message with call back number only

Please indicate below who we are allowed to disclose your personal health information to. This may include biopsy or labwork results, medications, appointments, etc. Please indicate their name and relationship to you. Please select "no one but myself" or indicate who we may speak to.

**Please note this does not include the release of personal health information to entities as stated in Section A (Uses and Disclosures which do not require your authorization) of Esterson Dermatology Notice of Privacy Practices.**

No one but myself_____

Name_____ Relationship_____

## ***HIPAA INFORMATION***

**I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information**

**SIGNED:_____ Date:_____**

__I understand that it is my responsibility to update my HIPAA release of information. I also understand that this can be done at any time by contacting the office directly.

__I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the rendering physician.

__I give my permission for the providers of Esterson Dermatology to treat, including any biopsy(s) or procedure(s), as deemed necessary in the exercise of their professional judgment.

__I understand that medical care requires my cooperation, and I will follow my provider's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

__I authorize the staff of Esterson Dermatology to take photographs to record my surgery/procedure. The office of Esterson Dermatology will only utilize these photos for comparison of cosmetic procedures, mole or area changes and may need to send the photos to the lab for further assistance in diagnosis.

__I understand that the photographs and recorded material may include appropriate portions of the body to demonstrate surgery/procedure(s) and that every effort will be made to protect the patient's identity in those materials.

I further acknowledge releasing any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to the third party payers, including Medicare.

Signature:_____ Date:_____