Dermatology Professionals, LLC

Notice of Patient Privacy Acknowledgment and Consent

We are required by law to protect the privacy of your medical information and to provide you with written notice describing: HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may use or disclose your medical information both created and received by this practice for purposes of providing or arranging for your health care. This may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. This may also include information regarding payment for or reimbursement of the care that we provide to you, and any related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information,, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise this notice from time to time. You have the right to receive a copy of our most current notice in effect. If you have not yet received a copy of out current NOTICE OF PRIVACY PRACTICES, please ask at the front desk and we will provide you with a copy.

If you have any questions about the NOTICE OF PRIVACY PRACTICES or your medical information, please contact our office at 503-344-6643.

_____ Patient's Initials

Authorization to Release Information Family and Friends

It is the office policy of Dermatology Professionals, LLC not to release confidential medical information regarding your treatment. If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretaker/babysitters, please indicate below.

1. _____ Relationship to Patient: _____

2. _____ Relationship to Patient: _____

_____ Initial to authorize the above named individual (s) to receive information regarding your treatment or care.

Authorization to Leave Messages with Household Members/Answering Machine

It maybe necessary that the staff at Dermatology Professionals to you leave messages regarding scheduled appointments as well as other information pertaining to your care. At no time will a staff member at Dermatology Professionals discuss your medical condition without your consent. By signing below you are allowing Dermatology Professionals to leave messages with household members or on your voicemail. *You have a right to revoke this consent in writing.*

_____ Initial to authorize messages.