**Authorization for Communication of Protected Health Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

The Health Insurance Portability and Accountability Act (HIPAA) requires First Coast Dermatology Associates to obtain your authorization to allow communications regarding your protected health information. This authorization allows First Coast Dermatology Associates to discuss your health care with a spouse, child, friend, or other family member that you designate. It also allows First Coast Dermatology Associates to leave recorded messages at your home, work, or on your cell phone related to your medical care and treatment, payment, appointment status, or follow-up.

**This authorization allows First Coast Dermatology Associates to discuss all aspects of my protected health information with those individuals listed below:**

**Name Relationship Phone Number**

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I understand that I may refuse to sign this authorization and realize this may result in a delay of treatment and/or have potential adverse health consequences. This authorization will expire in one year from the date signed; however, I may change or revoke it at any time. This signature does not authorize the release or disclosure of any of my written protected health information.

Signature of Patient or Legal Representative Date

Print Name of Patient or Legal Representative

***List phone number(s) IN ORDER OF PREFERENCE for receiving appointment reminder and/or patient care calls:***

 ***Please circle type: Phone Number:***

**1. Home / Cell / Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to leave message? Y / N**

**2. Home / Cell / Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to leave message? Y / N**

**3. Home / Cell / Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to leave message? Y / N**

**4. Other (2nd Home, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to leave message? Y / N**