

GATEWAY DERMATOLOGY

1 SOUTH WESTERN AVE
GLENS FALLS, NY 12801
(518)-745-5280

PATIENT NAME: _____ DATE OF BIRTH: _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature below, I provide this practice with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations (TPO) as described in the Privacy Notice.

With this consent, Gateway Dermatology may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, amongst others.

Gateway Dermatology may mail or e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, amongst others.

AUTHORIZATION FOR FRIENDS OR FAMILY

In addition to the use of my health information for treatment, payment or health care operations, I understand that I may request to designate a representative who can have access to my protected health information. If I wish to do this I can request the authorization form, "Limited Patient Authorization for Disclosure of Protected Health Information". (NOTE: Primary care Physicians and Minor's parents are automatic.)

RESTRICTIONS

I further understand that I have the right to request restrictions on the use or disclosure of my health information. Any specific restrictions and to whom I want the restriction to apply must be requested in writing. This is a separate form, "Patient Request for Restriction of Protected Health Information" that I can request.

If the office does not agree to the specific restriction, I will be notified and then have the right to use another healthcare professional.

(Signature of Patient or Patient's Representative)

(Date)

(Printed name of Patient's Representative)

(Relationship)

NOTE: TPO - treatment, payment and health care operations

*You have the right to receive a copy of signed authorizations upon request.

10/12/11:dmr