Dermatology Affiliates
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Suite 104A
Marietta, GA 30068-4382

Midtown
1109 West Peachtree Street NW
Atlanta, GA 30309-3608

Optional Consent – Methods of Communication

Patient Name: _____ **Patient DOB**: _____

I authorize Dermatology Affiliates, PC to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. This authorization shall be in effect until revoked by the patient.

I understand that I have the right to revoke this authorization at any time. I understand that before signing this document I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

☐ _____ (*check box and initial here*) If I select unencrypted email as a means of communication, I understand that unencrypted email is not secure. There is a possibility that information in an email can be intercepted and read by other parties beside the person to whom it is addressed.

Approved Methods of Communication to YOU	**Description of Information to be Released**
Check each method by which you approve us to release information to you (the patient).	Check each item that can be released by this method.
☐ Voicemail (provide phone #)	☐ Financial ☐ Medical as follows: _____ ☐ All information
☐ Text (provide phone #)	☐ Financial ☐ Medical as follows: _____ ☐ All information
☐ Email (provide email address)	☐ Financial ☐ Medical as follows: _____ ☐ All information

OTHER Approved Contacts	**Description of Information to be Released**
Check and name each person that you approve to receive information by phone, fax, or email.	Check each item that can be given to the person/entity on the left.
☐ Name: _____ Relation: _____ Contact:_____	☐ Financial ☐ Medical as follows: _____ ☐ All information
☐ Name: _____ Relation: _____ Contact:_____	☐ Financial ☐ Medical as follows: _____ ☐ All information
☐ Name: _____ Relation: _____ Contact:_____	☐ Financial ☐ Medical as follows: _____ ☐ All information

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Description of Personal Representative's Authority Patient Acct #