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| The Notice of Privacy Practice for the office of Brodsky Dermatology LLC is available for your review at the front desk and on our website at www.thederm.com. Should you wish to receive your own copy to take with you, please ask our receptionist. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at your next visit, to call our office and request a copy, or to mail a written request. |

I acknowledge receipt of the Notice of Privacy Practices for the office of Brodsky Dermatology LLC.

**Section 1 – Acknowledgement**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
*Patient Name Date of Birth Date*

**RELEASE OF MEDICAL INFORMATION & PATIENT RECORD OF DISCLOSURE**

**Section 2- Notification and Emergency Designee**

In general, the HPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). Individuals also have the right to request confidential communications or that communications of PHI is made by alternate means.

I wish to be contacted by Brodsky Dermatology in the following manner *(please check only one)*:

* Home Telephone (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(please check only one)*:
* Leave a message with detailed information
* Leave a message with call back number only
* Cell Telephone (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(please check only one)*:
* Leave a message with detailed information
* Leave a message with call back number only

With whom may we share medical information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature of Patient or Representative Date**

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Relationship of Representative**

**AUTHORIZATION TO RECEIVE MARKETING COMMUNICATIONS**

**Section 3 – Marketing Communication**

Brodsky Dermatology may wish to share new products, discounts or service information related to items or services provided by Brodsky Dermatology directly to you, our patient. If you agree, we will share such information with you via text message and/ or email.

By signing where indicated below, I agree to receive communications regarding products, discounts and services provided by Brodsky Dermatology:

* Via email to my Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Via text to my Cell Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I certify that the above is true and correct to the best of my knowledge. I understand the information provided to me in the privacy notice and I have indicated my response to the questions in each section***

I understand that Brodsky Dermatology will use my email and/or phone number only to inform me of its own services, and it will not share any information about me with any third-party for marketing purposes.

This authorization shall continue for so long as I am an active patient of Brodsky Dermatology, unless earlier revoked by me.

This authorization may be revoked in writing at any time by contacting our office by phone (847-843-3376), email (to Privacy Contact Nicole Baskerville at [npetrusonis@yahoo.com](mailto:npetrusonis@yahoo.com)), or in writing to [address], except to the extent that action has been taken in reliance on this authorization.

Brodsky Dermatology shall not condition treatment upon my execution of this Authorization.

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**Signature of Patient or Representative Date**

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Relationship of Representative**

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