Massachusetts Dermatology Associates, P.C.
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HIPAA

RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT FOR CLINICAL PHOTOGRAPHY
CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION

I acknowledge that I have received a copy of the Massachusetts Dermatology Associates 'Notice of Privacy Practices'. This notice describes how Massachusetts Dermatology Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices. If changes to the policy do occur, this practice will provide me a revised Notice of Privacy Practices upon my request.

I authorize the physicians/staff of Massachusetts Dermatology Associates, P.C. to take digital photographs that relate to my care. These photographs will be integrated into my electronic medical record.

I authorize the staff at Massachusetts Dermatology Associates, P.C. to access my prescription medication history from external databases to ensure accuracy of my medication history.

Massachusetts Dermatology Associates, P.C. or our agents may call my home, cell or other alternative location and leave a message on voicemail or in person, including but not limited to, appointment reminders, billing items and any calls pertaining to my care. I also authorize Massachusetts Dermatology Associates to share my medical information with other physicians involved in my care.

Personal Representative (Family members, attorney, etc.): I hereby authorize Massachusetts Dermatology Associates and its employees to discuss, send and/or receive medical information to/with the following person:
Please provide their name and phone number below:

Name_____ Relationship_____
Phone #_____

With my signature below, I submit that the above information is accurate to the best of my knowledge.
I voluntarily give consent for myself and/or my child to be examined and treated by the clinicians of Massachusetts Dermatology Associates, P.C.

_____ _____
(Signature of Patient, or Personal Representative) (Date)

_____
(Relationship to Patient)