Patient: ______________________________ **DOB:** ____________

I acknowledge receipt of the Notice of Privacy Practices for Innovative Dermatology.

X____ ____________________

Signature of patient/Responsible Party Date

____

Printed Responsible Party Name/ Relationship to patient

Authorization for Contact Methods

I hereby give Innovative Dermatology my permission to contact me at all of the contact numbers and addresses provided in order to communicate my protected health information (or that of my child) including results, prescriptions and appointment information. This communication may be via US mail, phone, answering machine, texting on mobile phone, or emailing. Please list restrictions below:

____

X ____ ____________________

Signature of patient/Responsible Party Date

Delegation of Patient Representative

By my signature below, I hereby authorize the disclosure of my Protected Health Information (PHI) (or that of my child), as well as appointments and billing information to be shared with the person(s) listed below.

DO NOT sign this section if you are not listing a delegate person(s) below

____

Name Relationship Phone

____

Name Relationship Phone

____

Name Relationship Phone

X ____ ____________________

Signature of patient/Responsible Party Date