APDerm®
DERMATOLOGY PROFESSIONALS

PERMISSION FOR VERBAL COMMUNICATION

Dermatology Professionals, Inc recognizes that patients may prefer family members or friends to be involved in their care. For example, a patient may want their spouse or adult child to assist with billing questions, to be informed about appointments on their behalf or to be updated of their health status. This form serves as a record of your wishes. Please complete this form if you would like to allow our healthcare team members to discuss your health information with a specific individual. This document does not permit release of any written health information to the individuals named.

_____ _____

(Print name of patient or place patient label here) (Date of birth)

Please list the individual(s) that you allow us to speak with about your care:

Family or Friend's Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____

I acknowledge and understand that:

- *I am allowing* Dermatology Professionals, Inc *to share information with the above-named individual(s) only by verbal discussions and that my permission does not give the above-named individual(s) access to my hard-copy or electronic medical record.*
- *The information I allow* Dermatology Professionals, Inc *to share is not limited unless specified:* _____ _____.
- *My permission will remain in effect for an unlimited amount of time unless another date is listed or I cancel my permission:* _____.
- *I can change my permission at any time by contacting the dermatology office where I receive care, but that my cancellation will not have an effect on information shared prior to my cancellation.*
- *Information shared with the above-named individual(s) may be further shared by them and not protected under confidentiality and privacy laws.*
- *My permission is voluntary, and* Dermatology Professionals, Inc *may not condition my treatment, payment or eligibility for services on my signature.*
- *If at any time I do not want my healthcare team members to discuss my healthcare information with the above-named individual(s), I must provide written notice to the dermatology office where I receive care or contact the privacy officer at (978) 849-7582 or 526 Main Street, Suite 302, Acton, Massachusetts 01720.*

By signing below, I acknowledge I have read, understand and agree with the information on this form and that all my questions have been answered in a language that I understand.

Patient/Guardian Signature:_____Date:_____

Representative's Name: _____Relationship to Patient : _____