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Authorization and Release for Use of Phone, Email & Voicemail Communications

PATIENT NAME: _____

Method of Communication and Contact

Please write the contact number or email on the line below:

Phone Contact _____ Email Contact _____

_____(Initials) **I grant consent for Medical and Surgical Dermatology to contact me via telephone calls.** If at any time I provide a telephone number (land line or wireless) at which I may be contacted, I consent to receive calls, voice messages or text messages at my expense. Calls and messages include but are not restricted to communications regarding medical care, billing and payment for products and services, unless I notify Medical and Surgical Dermatology in writing to the contrary.

_____(Initials) **I grant consent for Medical and Surgical Dermatology to contact me via email.** If at any time I provide an email address at which I may be contacted, at my expense I consent to receive email messages to include but are not restricted to communications regarding medical care, billing and payment for products and services, unless I notify Medical and Surgical Dermatology in writing to the contrary.

_____(Initials) **I understand that the use of phone, email, and voicemail communications are NOT secure forms of communication and that the confidentiality of any phone, email, or voicemail information cannot be guaranteed.**

By signing below, I consent to receive communications from providers and staff of Medical and Surgical Dermatology, LLC, its business associates, and contracted agents.

Patient of Patient Representative Signature: _____

Date: _____

PER HIPAA REQUIREMENT, THIS FORM MUST BE COMPLETED ANNUALLY.