

DERMATOLOGY ASSOCIATES OF CENTRAL NJ FREEHOLD SKIN CLINIC & CANCER CENTER

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CONSENT TO RELEASE INFORMATION AND COMMUNICATION INSTRUCTIONS

Date: _____ Patient Name: _____

I, _____ give my permission for

Name Relationship

Name Relationship

Dermatology Associates of Central NJ makes every effort to keep your information confidential. We comply with all applicable State and Federal privacy laws. We have a Notice of Privacy Practices posted on our website. We also have this Notice available in our offices. You have the right to receive a paper copy of this Notice. Please ask us any time to give you a copy of this Notice.

You may wish to check with us from time to time as the Notice of Privacy Practices may be revised.

We have found that most of our patients that request email communication with our office want to receive unencrypted email. We have also found that some of our patients prefer text messages. These texts are not on an encrypted or secure service. Do we have your permission to use your:

Home answering machine: ___ Yes ___ No (_____) _____ - _____

Work voice mail: ___ Yes ___ No (_____) _____ - _____

Cell phone voice mail: ___ Yes ___ No (_____) _____ - _____

Unencrypted email: ___ Yes ___ No (_____) _____ @ _____

Unsecure text: ___ Yes ___ No (_____) _____ - _____

If at any time you change your preference, please let us know. So Agreed and Understood _____, 201 _____

Patient Name: _____

Patient Representative: _____

Signature Date

I **do not** wish to have my medical results left on any answering machines, voice mails or emailed.

Signature Date