The Art and Science of Dermatology

Patient's Consent for Provider to Disclose PHI to Authorized Persons and Collections with Cell Phone Numbers and Email Addresses

1. **Authorization to Disclose PHI (Protected Health Information).** I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the persons indicated below.

2. **Persons to Whom Disclosure May be Made.** Provider may disclose my PHI to the following persons:

Name	Relationship, If Any	Phone Numbers
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. **Purpose of Disclosure**. The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

4. **Expiration of Authorization.** This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

5. **Conditioning of Treatment**. Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

6. **Redisclosure by Recipient.** I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may re-disclose my PHI, which may no longer be protected by federal or state law.

7. **Collections with cell phone numbers.** You agree, in order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone numbers associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you provide to us. Methods of contact may include using per-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that our collection agency may contact me/us as described above.

Acknowledgment of Reading and Agreement. I have read and understand all of the above authorization.

_____
Name of Patient (printed)

_____ _____
Signature of Patient Date

_____
Signature of Patient Representative (Required if patient is a minor or an adult who is unable to sign this form).

Relationship of Patient Representative to Patient: _____