



Kerry Shafran, MD, FAAD | Lindsay Jayson, PA-C | Keri Squittieri, PA-C | Mari Klos, CMA, LE

## COMMUNICATION & ACKNOWLEDGMENT FORM

Patient's name (Please print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Riva Aesthetic Dermatology is not permitted, by law, to provide medical information to anyone other than the patient except for treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

The staff at Riva Aesthetic Dermatology would like to know with whom, if anyone, you want us to be able to discuss your treatment, treatment plans, condition updates, lab results, appointment information, billing information, or picking up of samples. This would also include leaving messages on your answering machine or in your voicemail box. If you would also like us to communicate with you by e-mail to address your health information or for specials, promotions, or other office events, please indicate so below.

Please complete the following so that the individuals you specify can have access to your information as described above.

I, \_\_\_\_\_, as a patient of Riva Aesthetic Dermatology, authorize the release of my medical information regarding my treatment and care to the following individuals upon their request:

_____	_____	_____	_____
Name (please print)	Date of Birth	Relationship	Phone Number

_____	_____	_____	_____
Name (please print)	Date of Birth	Relationship	Phone Number

_____	_____
Signature of Patient / Authorized Representative	Date

**E-mail:** I, \_\_\_\_\_, authorize Riva Aesthetic Dermatology to e-mail me information regarding my care or for specials, promotions, or other office events that may become available. I understand that my e-mail address will be kept confidential in the same manner as all my other health related information.

(E-mail address at which I wish to be contacted): \_\_\_\_\_

**By signing below I authorize Riva Aesthetic Dermatology to communicate protected health information to me as described above. I further acknowledge that I have been given the opportunity to read the Notice of Privacy Practices for Riva Aesthetic Dermatology describing how my protected health information may be used and disclosed as permitted under federal and state law. I understand that I may obtain a complete copy of the Notice for my records upon request at any time. My consent will remain in effect as long as I am a patient of Riva Aesthetic Dermatology unless and until I notify Riva Aesthetic Dermatology in writing of any changes.**

Please Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient/ Authorized Representative: \_\_\_\_\_

Relationship to Patient (If person other than patient signing this form): \_\_\_\_\_

**For Office Use Only:** Reason Patient unable/unwilling to sign: \_\_\_\_\_ (rev. 11/12)

