

SUTTON PLACE DERMATOLOGY
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As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the U.S Department Of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes Drs. Lombardo, Foitl and Schadlow to send my medical information as noted:

Leave a voicemail recording including my Personal Health Information on my indicated home/cell phone: _____yes _____no

Leave a voicemail recording including my Personal Health Information on my business phone: _____yes _____no

Permit Drs. Lombardo, Foitl and Schadlow to share my Personal Health Information with other health care providers as necessary to carry out my care: _____yes _____no

Permit Drs. Lombardo, Foitl, and Schadlow to send Personal Health Information to the following indicated email account: _____yes _____no

Email Address: _____

Permit the individual stated below (family member/friend) to receive prescriptions, test results, and/or other Personal Health Information on my behalf: _____yes _____no

Name of family member/friend: _____

I received and reviewed Sutton Place Dermatology's Notice of Privacy Practices, which describes how my medical information may be used and disclosed.

_____ Print Patient Name/Date

_____ Patient Signature/Guardian