SP

SUTTON PLACE
DERMATOLOGY

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 Dr. Foitl 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 Dr. Foitl to share my Personal Health Information with other health care providers as necessary to carry out my care: ☐ YES ☐ NO

Permit Dr. Foitl 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