ZALADONIS
DERMATOLOGY
ASSOCIATES

DERMATOLOGY AND DERMATOLOGIC SURGERY

Joseph J. Zaladonis, Jr., MD | Mary E. Hutchins, MD | Veronica L. Rutt, DO

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY

FELLOW AMERICAN ACADEMY OF DERMATOLOGY

HIPPA RELEASE OF INFORMATION

NAME: _____ DOB: _____

☐ I authorize the release of information including the diagnosis, medical examination, and claims information rendered to me. This information may be released to and/or my primary care physician:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

☐ I do not want my information released to anyone other than myself and/or my primary care physician.

PHONE MESSAGES

Please call: Home:_____ Work: _____

Cell: _____ Email: _____

The information provided above may be used by our office staff and an automated reminder call system.

This policy shall remain in effect until terminated by me in writing.

Signature:_____ Date: _____

1665 Valley Center Parkway, Suite 120 | Bethlehem, PA 18017 | 610.868.3150 | Fax: 610.868.3156| www.zaladonisderm.com

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Zaladonis Dermatology Associates may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Zaladonis Dermatology Associates' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Zaladonis Dermatology Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy of Practices may be obtained by forwarding a written request to Zaladonis Dermatology Associates, Privacy Officer at 1665 Valley Center Parkway, Suite 120, Bethlehem, PA 18017.

With my consent, Zaladonis Dermatology Associates may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Zaladonis Dermatology Associates may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Zaladonis Dermatology Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Zaladonis Dermatology Associates use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Zaladonis Dermatology Associates may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I,_____, have received a copy of Zaladonis Dermatology Associates' Notice of Privacy Practices.

_____ _____
Signature of Patient Date