Skin Scape®
AESTHETICS • VEIN • LASER

Authorization for Communication of Protected Health Information

Patient Name (print) Date of Birth

It is frequently necessary for personnel at this practice to communicate information about lab results, instructions, appointments, treatment, payment and other items of protected health information with, or ask for feedback from, our patients. It is often not possible to personally speak with the patient to communicate this information. Please provide us instructions regarding your communication preferences, including what you would like us to do if we are not able to reach you (the patient) directly.

1. Messages may be left for me on my Mobile phone voicemail @ _____

2. My home answering device does not identify me by name, but it is appropriate to leave message for me there. (circle) Yes or No

3. Messages may be communicated to me via email @ _____

4. Messages may be left on my home answering device @ _____

5. Messages may be communicated by texting on my cell phone @ _____

   I understand that texting is not a secure method of electronic communication, and there is a possibility that texts can be read by someone other than the intended recipient. I still wish to receive text reminders for upcoming appointments and other messages.

6. Other person(s) authorized to receive messages on my behalf:

   A) Name _____ @ _____

   B) Name _____ @ _____

I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time. This authorization does not expire unless otherwise revoked in writing.

Signature of Patient or Patient/Guardian Date

Relationship to Patient if Minor