HIPAA Release

Call Preference-please list call preference in order from number 1-3

☐ Home ___ ☐ Work ___ ☐ Cell ___

Is there a location we should *not* call? Please list: _____

I hereby give permission to Seeberger Dermatology, LLC. To notify me by telephone of the following:

☐ Appointment reminder, either by personal/recorded message or text

☐ A message to call the office for test results (actual result will not be left)

☐ If results are benign, a message will be left, stating no further treatment would be needed and to keep any advised follow up as recommended by your provider

I authorize Seeberger Dermatology, LLC to disclose my medical information pertaining to my diagnosis and/or treatment, lab results, medical history, or any other such related information to myself and those listed below:

_____

Name **Telephone #** **Relationship**

☐ Emergency Contact **☐Power of Attorney** **☐ Copy of POA paperwork on file**

_____

Name **Telephone #** **Relationship**

☐ Emergency Contact **☐Power of Attorney** **☐ Copy of POA paperwork on file**

Assisted living/Long term care facility residents

Power of Attorney: _____

Name **Telephone #** **Relationship** **☐ Copy of POA paperwork on file**

Please list any facility personnel we are allowed to speak with on your behalf regarding your medical information:

_____

Name **Telephone #** **Relationship**

All patients

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize the release of this information to other health care providers associated with my care to facilitate further heath care treatment. I further understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of my medical information.

Signature Date