Notice of Patient Privacy Acknowledgment and Consent

We are required by law to protect the privacy of your medical information and to provide you with written notice describing: HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may use or disclose your medical information both created and received by this practice for purposes of providing or arranging for your health care. This may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. This may also include information regarding payment for or reimbursement of the care that we provide to you, and any related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise this notice from time to time. You have the right to receive a copy of our most current notice in effect. If you have not yet received a copy of our current NOTICE OF PRIVACY PRACTICES, please ask at the front desk and we will provide you with a copy.
If you have any questions about the NOTICE OF PRIVACY PRACTICES or your medical information, please contact our office at 248-814-7546.

_________**Patient's Initials**

Authorization to Release Information Family and Friends

It is the office policy of Dermatology Center of Lake Orion is not to release confidential medical information regarding your treatment. If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretaker/babysitters, please indicate below.

1. ____________________________________ Relationship to Patient: ________________________

2. ____________________________________ Relationship to Patient: ________________________

________ **Initial to authorize the above named individual(s) to receive information regarding your treatment or care.**

Authorization to Leave Messages

It may be necessary that the staff at Dermatology Center of Lake Orion leave you messages regarding scheduled appointments, as well as other information pertaining to your care (i.e.: pathology and lab results). At no time will a staff member at D.C.L.O discuss your medical condition without your consent. Please indicate below by checking the corresponding box of your preference. *You have a right to revoke this consent in writing.*

☐ I allow Dermatology Center of Lake Orion to leave voice messages reminding me of upcoming appointments at the following number:__________________________

☐ I allow Dermatology Center of Lake Orion to leave detailed voice messages regarding personal information relating to my care (i.e.: pathology or lab results) at the following number:____________________

☐ I decline to have Dermatology Center of Lake Orion any voice messages

Patient Signature: ____ **Date:** ___________________

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