**PATIENT COMMUNICATION FORM**

**PATIENT NAME: _____ DATE OF BIRTH _____**

It is the office policy of Basko Dermatology not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian (if under age 18); (ii) other persons authorized by the patient; (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment); (iv) in emergency situations; or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize Basko Dermatology to contact me (*indicate phone number if authorized):*

| | | | |
|---|---|---|---|
| _____ Home | Leave a message: | ◯ Yes | ◯ No |
| _____ Cell | Leave a message: | ◯ Yes | ◯ No |
| _____ Work | Leave a message: | ◯ Yes | ◯ No |

If you anticipate you will need or want your medical or financial information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical or financial information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later, please confirm this in writing).

| PERSON | RELATIONSHIP | MEDICAL | | FINANCIAL | |
|---|---|---|---|---|---|
| | | PLEASE INITIAL | | | |
| _____ | | ___ yes | ___no | ___yes | ___no |
| _____ | | ___ yes | ___no | ___yes | ___no |
| _____ | | ___ yes | ___no | ___yes | ___no |
| _____ | | ___ yes | ___no | ___yes | ___no |
| _____ | | ___ yes | ___no | ___yes | ___no |

PATIENT / PARENT / GUARDIAN SIGNATURE: _____

DATE _____

***This consent will remain in effect until further written notice from you is received***