Island
DERMATOLOGY LLC

HIPAA RELEASE OF INFORMATION

CONTACT PREFERENCE

I prefer to be contacted by:

☐ Cell Phone Number ☐ Email
☐ Home Phone Number ☐ Other: _____

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

☐ Appointment reminder, either by personal/recorded message or text message
☐ A message via voicemail or text to call the office for path/lab results (actual result will not be left)
☐ If path/lab results are benign, a voicemail and/or text message will be left, stating no further treatment would be needed.

I hereby opt into receiving Koru Medical Spa specials/discount via email and/or text messages:

☐ Yes
☐ No

I authorize Island 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

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ASSISTED LIVING/LONG TERM FACILITY CARE 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 #	Facility Personnel Title

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.

Patient Printed Name	Patient Signature	Date