AUTHORIZATION & PRIVACY NOTICE

www.susongderm.com

Patient's Name: ____ Date of Birth __________________________
(Please Print)

In an effort to protect each person's privacy, C Rodney Susong, MD PC and their staff are NOT allowed to give information on any patient, whether by phone or in person, without the written permission from the patient. We will NOT allow a person other than yourself to pick up medical records, test results, disability forms, prescriptions, etc., unless prior written consent is obtained from you the patient or responsible party.

Please specify the people you are giving written permission for:

Name: ____ Relationship: _____________________________
(Please Print)

Name: ____ Relationship: _____________________________
(Please Print)

Name: ____ Relationship: _____________________________
(Please Print)

Name: ____ Relationship: _____________________________
(Please Print)

Do we have your permission to call your home/work/cell to discuss appointments, scheduling of tests and/or procedures as well as results of tests and/or procedures? Please **circle** all that apply:

HOME WORK CELL

May we leave a message at your home to persons other than yourself and/or on an answering machine to call our office?

Please circle one: YES NO

I acknowledge receiving/being offered today a copy of the Provider's Notice of Privacy Policies. I may pick up a copy at the front desk. By signing below, I am authorizing the practice to disclose my protected health information to the person's I have listed above or to other health care providers involved in my medical treatment. I understand my rights and how to revoke this permission as described in the Notice of Privacy Practices offered to me by the practice.

PATIENT/GUARANTOR SIGNATURE ___________________________________ DATE ______________________

Missed appointments without a compelling reason may be charged a no-show fee up to $100 unless 24 hours' advance notice is given.
Visit our website at www.susongderm.com for more information.