Boynton Beach Dermatology / Joseph C Gretzula DO

NEW PATIENT NOTICE OF PRIVACY
AND DISCLOSURE OF HEALTH INFORMATION

I understand that as part of my healthcare, Boynton Beach Dermatology, and its physician(s) originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that as part of this organizations treatment, payment, and healthcare operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

The complete Privacy Notice of Boynton Beach Dermatology, and its physician(s) is available in the office for my perusal. I may also request my own copy if I desire.

I fully understand and accept the terms of this consent.

Patient Name (print): _____ Date: _____
Patient Signature: _____
Parent or Authorized representative (if applicable): _____
If patient is a minor (under 18) check relationship: □ Mother □ Father □ Other _____

Please complete the following information:

Name of person(s) with whom we may discuss your medical information (i.e. wife / husband, child, etc.)

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

May we leave a message on your answering machine for the following:
Laboratory / Pathology Results: □ Yes □ No