DERMATOLOGY ASSOCIATES OF CENTRAL NJ
FREEHOLD SKIN CLINIC & CANCER CENTER
UNION DERMATOLOGY
TOMS RIVER DERMATOLOGY

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732-679-6300

CONSENT TO RELEASE INFORMATION AND COMMUNICATION INSTRUCTIONS

Date: _____ Patient Name: _____

I, _____ give my permission for

_____ _____
Name Relationship

_____ _____
Name Relationship

Dermatology Associates of Central NJ makes every effort to keep your information confidential. We comply with all applicable State and Federal privacy laws. We have a Notice of Privacy Practices posted on our website. We also have this Notice available in our offices. You have the right to receive a paper copy of this Notice. Please ask us any time to give you a copy of this Notice.

You may wish to check with us from time to time as the Notice of Privacy Practices may be revised.

We have found that most of our patients that request email communication with our office want to receive unencrypted email. We have also found that some of our patients prefer text messages. These texts are not on an encrypted or secure service. Do we have your permission to use your:

Home answering machine: ____ Yes ____ No (____) _____ - _____

Work voice mail: ____ Yes ____ No (____) _____ - _____

Cell phone voice mail: ____ Yes ____ No (____) _____ - _____

Unencrypted email: ____ Yes ____ No (____) _____ @ _____

Unsecure text: ____ Yes ____ No (____) _____ - _____

If at any time you change your preference, please let us know. So Agreed and Understood _____, 20_____.

Patient Name: _____

Patient Representative: _____

_____ _____
Signature Date

I **do** **not** wish to have my medical results left on any answering machines, voice mails or emailed.

_____ _____
Signature Date