Dermatology SouthEast
ST. JOHNS

Name: ______________________________________ Date:______________

Medication History Patient Consent

I agree that Dermatology SouthEast St. John's may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

___________________________________ ________________
Patient Signature Date

Pharmacy Information:

Pharmacy Name: ____

Street: ______________________________ City: ______________________

Phone Number: (If you know it) _______________________________

Dermatology SouthEast
ST. JOHNS

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that I received the Notice of Privacy Practices from Dermatology SouthEast St. John's, which sets forth the ways in which my personal health information may be used or disclosed by Dermatology SouthEast St. John's Physicians, and outlines my rights with respect to such information.

____
Patient signature

____
Date

PHONE CONTACT AUTHORIZATION

Your signature authorizes Dermatology SouthEast to disclose your personal health information in the following manner:

Voice mail at home: Yes No

Voice mail at work: Yes No

Also please list the individuals with whom we may discuss your information:

Name	Relationship

I understand that I may revoke this authorization by contacting Dermatology SouthEast in writing.

Print name	Signature	Date