



Bryn Mawr
DERMATOLOGY

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PRIVACY STATEMENT

Please check off and complete only one section

- I authorize your practice to disclose my Personal Health Information by phone, letter, or fax to myself and my immediate family and, if necessary, to leave information on an answering machine.

Patient's Name _____

Patient's Signature _____ Date _____

Note: The message may include medical tests results, appointment reminders, and prescription refills and changes. This authorization is valid indefinitely unless you notify us otherwise.

- I do not authorize your practice to disclose my Personal Health Information by phone, letter, or fax to anyone other than myself.

I request the following restrictions:

Patient's Name _____

Patient's Signature _____ Date _____