OASIS
DERMATOLOGY

1055 N. La Canada Drive, Ste. 101
Green Valley, AZ 85614
520-589-2039
www. oasisdermaz. com

Primary Dr: _____ Pharmacy Name/Cross Streets: _____

Patient Email : _____ Need Access to our Patient Portal access: Yes or No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that

(Name of Patient)

a copy of OASIS DERMATOLOGY's **'Notice of Privacy Practices'** is available to me upon request. This Notice describes how OASIS DERMATOLOGY may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

(Signature of Patient, or Personal Representative) (Date)

▢ I authorize Oasis Dermatology staff to contact me via SMS text messaging.

▢ I authorize Oasis Dermatology staff to leave a detailed voicemail.

Personal Representative (Family members, attorney, etc.): I hereby authorize Oasis Dermatology and its employees to discuss, send and/or receive medical information to/with the following.

Please provide their names and and phone numbers below:

1. Name _____Relationship _____
Phone # _____

2. Name _____Relationship _____
Phone # _____