



DERM|sa

DERMATOLOGY

ASSOCIATES of

SAN ANTONIO

## Email Authorization Form

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Dermatology Associates may not condition treatment, payment, enrollment or eligibility for benefits based on whether an individual signs the below authorization form. Any written revocation of the below authorization shall be effective except to the extent that Dermatology Associates has previously taken action in reliance on the authorization.

I hereby authorize Dermatology Associates as my Health Care Provider to use the e-mail address listed on the attached patient intake form to contact me concerning products, services, therapies, procedures or treatments. I understand that my e-mail address may be considered individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and that such information could be reasonably used to identify me as a patient of Dermatology Associates. I hereby release Dermatology Associates from any liability that may be incurred from the use of my e-mail address to contact me concerning health-related products, services, therapies, procedures or treatments.

This authorization is in addition to other medical release authorizations I may have granted in the past or future and does not replace them. This authorization is effective as of the date shown as the date of its signing. This authorization shall terminate on the first to occur of: (1) my death or (2) upon my written revocation actually received by Dermatology Associates. By signing this authorization, I readily acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected by the HIPAA rules. I fully indemnify Dermatology Associates for all consequences which may occur as a result of their good faith reliance and compliance with this authorization.

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Signature of Responsible Party

Date