Newport Dermatology & Laser Associates
1441 Avocado Ave #806 Newport Beach, CA 92660
949-718-1222

Acknowledgement of Notice of Privacy Practices

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for Newport Dermatology & Laser Associates. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy is available on our website at www.drdoregilbert.com and in our office. You may request a copy of the Notice of Privacy.

Signature: _____ Date: _____

Print Name: _____

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Authorization for Release of Personal & Health Information

Newport Dermatology & Laser Associates require specific written authorization for the disclosure of any personal and health information.

1. I, the Undersigned, Authorize:
Newport Dermatology & Laser Associates/ Dore Gilbert, MD / Michelle Aszterbaum, MD/ Melissa Gilbert PA-C.

2. To Release information from the Records of:

Patient's Name: _____ Date of Birth: _____

3. Information Authorized for Release (**check all that apply):**

___ Medical Information _____ Payment / Billing Information

Can leave a voice mail message with results @ (_____) _____

4. I authorize disclosure of my protected health information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

5. Signature

I, _____, have had full opportunity to read and consider the contents of this authorization. By Signing this form, I understand I am authorizing release of personal and health information to a third party named in this document. This authorization shall remain in effect until it is revoked by request in writing.

Signature: _____ Date: _____

Print Name: _____