MEDICAL SKIN THERAPEUTICS
4801 DORSEY HALL DRIVE
SUITE 204
ELLICOTT CITY, MD 21042

NOTICE OF PRIVACY PRACTICES

Health care providers are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. As we collect health information from you, we store it in a chart and possibly on a computer. This is your health care record and while it is our property, the information in it belongs to you. As we treat you, we want to assure you that we protect the privacy of your health information.

As part of our continuing efforts to protect your privacy, we would like to know the best way to contact you. This information will include:

Best Way to Contact You – Telephone, Email, etc.: ________________________________

Or do not contact me: ____

I acknowledge and understand my rights regarding privacy practices.

________________________________ ________________
Signature of Client Date

Name of Guardian if under 18 years old: ________________________________

CLIENT RIGHTS AND PRIVILEDGES

I may ask as many questions as I consider necessary to understand the nature of my care, its objectives, its limitations and its possible complications.

I agree to pay for care at the time it is received.

________________________________ ________________
Signature of Client Date

I hereby authorize Medical Skin Therapeutics to share my medical information with the following people:

Name:________________________________ Relationship:____________________

Name:________________________________ Relationship:____________________

CONSENT FOR MEDICAL PHOTOGRAPHY

I consent for medical photographs to be made of me. I understand that the photographs may be used in my medical record and for purposes of medical teaching. Please check one of the options below.

☐ I agree to have my photograph taken

☐ I do not agree my photograph to taken