PRIVACY PROTECTION AGREEMENT

In connection with the medical services that I am receiving from Water's Edge Dermatology, Inc., a Florida corporation (the "Practice") including its medical and other staff, I, _________________________ (referred to as "I", "me", "my" or the "Patient"), hereby authorize the Practice, and its respective employees and agents to disclose any information concerning my medical condition and treatment (including, but not limited to, super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence, or other such information), including copies of applicable hospital and medical records, to:

a. Any third party payer covering the medical services of the Patient;
b. Other health care professionals and institutions involved in the delivery of health care to the Patient;
c. The proponent of any legally sufficient subpoena, or in response to a court order;
d. Employees and agents of the Practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
e. Pharmacies; and
f. As otherwise required by law

at the request of any person or entity for any of the above-described purposes, or at the request of the undersigned Patient.

I understand that this authorization is voluntary and is not a condition to treatment, enrollment in the health plan, or eligibility for benefits.

I understand that there is a potential for the information that is disclosed pursuant to this authorization to be re-disclosed by the recipient and then will no longer be protected.

I further consent that photographs may be taken of me or parts of my body to be used as part of my medical records.

In each case, the Practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above.

I also hereby authorize the disclosure of personal health information to those persons that I choose to accompany me in the office during my examination.

I also expressly authorize the disclosure of personal health information in the following manner and to the following person(s) (please initial all that apply):

Answering machine/voicemail:_______

The following individuals: ___________________________________ Birthday: __________________
___________________________________ Birthday: __________________
___________________________________ Birthday: __________________

Special Restrictions: ____
____
____

This consent is valid from the date signed until revoked in writing by the Patient.

I have received a copy of this agreement.

____
Please Print Patient Name

____ Date:____________________
Signature of Patient or Guardian

____
Relationship to Patient

WED08-0511