DR. JEFF DONOVAN

DERMATOLOGIST, SPECIALIZING IN HAIR LOSS

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PHYSICIAN TO SPECIALIST CONSENT FORM

Dear Patient,

I have received a request to discuss your file via phone with another physician or member of your health care team. ***I will need your permission to discuss your health and medical file with another physician or specialist.***

Please complete the attached form in full. I am happy to review your file and discuss management with your physicians. Please note that if you require me to continue to dialogue with your specialist, I will require you to book a follow up appointment either by phone or skype at least every 6 months so that I can keep up to date with your progress.

I take issues related to privacy of personal health information very, very seriously – and thank you for your cooperation in this matter.

Yours truly,

Jeff Donovan MD Dermatologist

REQUEST FOR DR. DONOVAN TO DISCUSS MY HEALTH WITH OTHER SPECIALISTS

***PATIENTS ARE REQUIRED TO FILL OUT THIS FORM IN FULL. PLEASE DO NOT LEAVE ANY SPACE BLANK*. USE A SEPARATE FORM FOR EACH SPECIALIST**

Dear Doctor Donovan,

My name is _____ and my date of birth is

_____. I hereby give permission for you to discuss my hair loss

with the following health care professional by phone.

NAME OF HEALTH CARE PROVIDER: _____

ADDRESS OF HEALTH CARE PROVIDER:

_____

_____

_____

FAX NUMBER OF HEALTH CARE PROVIDER:

_____

_____

_____

EMAIL ADDRESS OF HEALTH CARE PROVIDER:

_____

_____

_____

TYPE OF PRACTIONER: _____

By signing this form, I confirm that I have **already** spoken with the above specialist about the two of you talking about my case and **confirm that my specialist has also agreed to speak to you**. I will send the contact information (phone number) for my specialist to your office.

You also have permission to discuss ANY and ALL aspects of my health that you are aware of with this practitioner. I consent to you faxing all prior consultation notes and blood tests to this physician. If there are issues I do not permit you to discuss with the above person, I will include them on the lines below:

_____
_____
_____
_____
_____
_____
_____

I understand this consent will last 7 months. I understand that I can refuse to sign this consent form. However, I understand that Dr. Donovan will not discuss my medical file with the above individual in that case. I understand that there is a fee associated with Dr Donovan speaking with my other health care specialists about my case.

X_____ _____ _____

SIGNATURE OF PATIENT FULL NAME OF PATIENT TODAY'S DATE

This form confidential and intended only for the named recipient(s). Any unauthorized use or disclosure is strictly prohibited.