dermatology CONSULTANTS

Release of Medical Information

Patient Consent for Use and Disclosure of Protected Health Information

The items below are to protect your healthcare information and provide consent to contact you regarding your care. Please check the appropriate boxes and fill in the appropriate information.

☐ **I hereby give my consent for Dermatology Consultants, P.A. to use and disclose protected health information about me to carry out treatment, payment and healthcare operations to third party payers.**

☐ **PHONE CONTACT**

Dermatology Consultants, P.A. may call the numbers below in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, insurance items and messages pertaining to my clinical care including laboratory results.

Please check message options for each number.

Home phone _____ ☐ no message ☐ message to call ☐ detailed message

Cell phone _____ ☐ no message ☐ message to call ☐ detailed message

Work phone _____ ☐ no message ☐ message to call ☐ detailed message

If there is anyone else who can take a message about your healthcare or results, please provide information below:

Name _____ Relationship _____

Additional phone _____ ☐ message to call ☐ detailed message

☐ **MAIL CONTACT**

Dermatology Consultants, P.A. may mail to my home or alternative location provided below any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and financial statements.

Please provide the preferred address for mailings.

Address _____

_____

☐ **E-MAIL CONTACT**

Dermatology Consultants, P.A. may e-mail to the address provided below any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder and financial statements.

Please provide the preferred address for e-mail.

E-mail address _____

Signature	Date
Printed name	Date of birth

This consent is valid for one year unless invoked in writing.

ADDITIONAL INFORMATION

Pharmacy name _____ Location _____ Phone _____

Primary physician name _____ Location _____ Phone _____