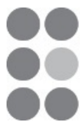

Patient Name ____

Patient Date of Birth: ____

Patient Authorized Protected Health Information Disclosure To Others

I (name) ____give my permission to release my protected health information to the following individuals:

Name: ____ **Relationship:** __________________________

Is this person a patient at Center for Dermatology? (Please circle one) YES NO

Name: ____ **Relationship:** __________________________

Is this person a patient at Center for Dermatology? (Please circle one) YES NO

Name: ____ **Relationship:** __________________________

Is this person a patient at Center for Dermatology? (Please circle one) YES NO

Patient Signature: ____ **Date:** _______________________

Patient Contact

Center for Dermatology will remind you of your appointment. Please provide as many options as possible so we are able to provide you an appointment reminder.

*Providing your email address also gives you access to your patient portal.

Preferred Method of Contact (Appointment Reminders)

Text – Cell Phone Number ____

By submitting your phone number, you are authorizing Center for Dermatology to send you text messages and notifications (opting-in). Message/data rates apply. Reply STOP2END to unsubscribe to a message sent from Center for Dermatology.

Email – Email Address* ____

Telephone call – Phone Number ____

- You may change your method of contact any time by calling Center for Dermatology

Patient Signature: ____ **Date:** _______________________

This signed document is valid until revoked in writing to Center for Dermatology by the patient/signer.