Dermatology Center
FOR SKIN HEALTH PLLC

CONSENT TO COMMUNICATE/DISCUSS/RELEASE CONFIDENTIAL MEDICAL AND BILLING INFORMATION

NAME OF PATIENT: _____ DATE OF BIRTH: _____

The Dermatology Center for Skin Health, PLLC will be sending automatic appointment reminders to you by email, text, and phone prior to upcoming appointments.

When our office needs to reach you to discuss medical or billing information, I authorize the following methods for communication:

Cell phone: _____ May we leave a message? _____
Home phone: _____ May we leave a message? _____
Mail: _____

I authorize the following person(s) to have access to my medical and billing information.
PLEASE NOTE: If you do not want anyone to have access to your record, write NONE in the first Name space.

NAME: _____ RELATIONSHIP: _____ DOB: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ DOB: _____ PHONE: _____

This authorization shall be in force and effect until the time or event specified below at which time this authorization to use and disclose this information expires.

EXPIRATION: _____

I understand and authorize the Dermatology Center for Skin Health, PLLC to utilize the above communication method(s) with me and that the person(s), listed above, may have access to my medical record and billing information.
I understand that information used or disclosed pursuant to this authorization may be disclosed by recipient and may no longer be protected by federal or state law.
I understand that I may update this information in my file ***at any time*** by completing another document for my file.

PATIENT SIGNATURE: _____ DATE OF SIGNATURE: _____