RELEASE OF PERSONAL HEALTH INFORMATION

Name:_________________________________ **Date Of Birth:**_________________________

Home Phone:_____________________________ **Cell Phone:**____________________________

Preferred Contact method (circle one): Home Phone Cell Phone

Do we have your permission to…

Leave a detailed message on your (circle one): Home Phone Cell Phone

Discuss your medical condition with any member of your household? (circle one) YES NO

If yes, whom? _____________________________Relationship___________________________

Patients under 18 years of age:

Name of parent/guardian:_______________________ Contact number: _______________________

Name of parent/guardian:_______________________ Contact number: _______________________

Email:____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I am aware of the Provider's Notice of Privacy Practices posted at Town Square Dermatology. The Notice of Privacy Practices describe how identifiable health information may be used and disclosed and states your rights with respect to your medical information.

I understand that Town Square Dermatology has the right to revise these information practices and to amend the Notice of Privacy Practices. I understand that in the event that the notice is revised, the revised notice will be posted at Town Square Dermatology. At any time, upon request, I may obtain a copy of the Privacy Practices Policy.

By signing below I affirm that the above information is correct. If any changes should occur I will contact Town Square Dermatology to update my file.

____ ________________________________

Signature of Patient/Guardian/Representative Date Signed