REN Dermatology & LASER CENTER

HIPAA RELEASE FORM

PATIENT INFORMATION

Patient Name: _____**Date of Birth:** _____ /_____ /_____

Mailing Address: _____

PREFERRED CONTACT METHOD

Please call: (_____) _____-_____ □ Cell phone □ Home phone □ Work phone

Please text: (_____) _____-_____

Please email: _____

If unable to reach:

□ You may leave a detailed message on preferred contact method
□ Please leave a voicemail asking to return your call
□ **DO NOT LEAVE MESSAGES ON PHONE MAILBOX**

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis, records, examination results, medication dose changes, and claims information. This information may be released to:

Spouse: _____ **Phone Number:** (_____) _____-_____

Child: _____ **Phone Number:** (_____) _____-_____

Other: _____ **Phone Number:** (_____) _____-_____

☐ **INFORMATION IS NOT TO BE RELEASED TO ANYONE OTHER THAN ME**

RELEASE OF INFORMATION- OUTSIDE MEDICAL PROVIDER

If you would like your records sent to another provider outside of REN Dermatology, please enter their information here:

Provider's Name: _____***Phone:*** (_____) _____-_____

Practice Name: _____ **Fax*:*** (_____) _____-_____

AUTHORIZATION

Signature*:* _____ **Today's Date*:*** _____ /_____ /_____
(Patient or Parent/Guardian)

This release will expire 12 months after signature date. Release will remain in effect for 12 months until terminated by me (or child's parent/guardian) in writing.