

REN

DERMATOLOGY

AND AESTHETICS

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.