REN
DERMATOLOGY

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: _____

Please check one box below. If unable to reach:

☐ You may leave a detailed message on preferred contact method (regarding pathology, scheduling, etc.).

☐ Please leave a voicemail only 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.