Dermatology Associates, LLC

50 Sewall Street, Portland, ME 04102 Tel: (207) 775-3526 Fax: (207) 775-5658
57 Barra Road, Biddeford, ME 04005 Tel: (207) 282-3010 Fax: (207) 282-2360

PERMISSION TO GIVE OUT INFORMATION

Please list below only the names of the person and/or persons that you wish to give permission for our staff to speak to regarding your medical and/or financial information.

I, _____hereby grant the physicians and staff of Dermatology Associates, LLC my permission to speak with the following people in regard to my health and medical condition:

1. Name: _____ Relationship: _____

Telephone #'s: _____ _____ _____
Home Work Cell

2. Name: _____ Relationship: _____

Telephone #'s:_____ _____ _____
Home Work Cell

Effective date: From: _____To: _____

The following information may be given to the above individual(s) (please check all appropriate boxes):

☐ 1. Appointment Time
☐ 2. Financial Information
☐ 3. Test/Lab Results
☐ 4. Medications
☐ 5. Procedures
☐ 6. Other information regarding my Health

I understand I may revoke this consent at any time by giving written notice to Dermatology Associates, LLC.

Signed: _____ Date: _____

Printed Name: _____ Account Number: _____