DERMATOLOGY ASSOCIATES, LLC

PERMISSION TO GIVE OUT INFORMATION

☐ **I do not** wish to give permission to the physicians and staff of Dermatology Associates to speak to anyone in regard to my medical and/or financial information.

___

Do you have a Medical Power of Attorney (POA)? ☐ YES ☐ NO

-If yes, please list their name here: ____.

-Please provide us a copy of the POA paperwork so we can include it in your chart.

Please list below only the names of the person and/or persons that you wish to give permission for our staff to speak with regarding your medical and/or financial information. (Our staff is already allowed to speak with your primary care physician (PCP)/referring physician.)

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

1. Name: ____ Relationship: _________________________

2. Name: ____ Relationship: _________________________

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

- ☐ 1. Appointment Date/Time
- ☐ 2. Financial/Insurance Information
- ☐ 3. Biopsy/Lab Results
- ☐ 4. Medications/Prescriptions
- ☐ 5. Procedures
- ☐ 6. Referrals
- ☐ 7. Diagnoses

I understand that this consent will **expire 30 months** after the date it was signed. I also understand I may revoke this consent at any time by giving written notice to Dermatology Associates, LLC.

Signed: ____ Date: _________________________________

Printed Name: __________________________________ DOB: _________________________________