PERMISSION FOR VERBAL COMMUNICATION

If you would like to grant someone other than yourself, permission to discuss your Healthcare information with a member of Skin Dermatology please complete this form.

Patient Name: ________________________________ Birth Date: ___________________

I permit Skin Dermatology, their physicians, team members, and other personnel (“Healthcare Providers”) to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person’s relationship to the patient). This authorization is limited to discussions regarding the following medical condition(s):

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(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.)

Name: ____________________________ Phone: ______________ Relationship _________________

Name: ____________________________ Phone: ______________ Relationship _________________

Name: ____________________________ Phone: ______________ Relationship _________________

Name: ____________________________ Phone: ______________ Relationship _________________

Release of information under this document is limited to verbal discussions with my healthcare providers. This document does not permit release of any written health information to the individuals named above. This authorization is limited to the following timeframe from ____________ (date) to ____________ (date). If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my healthcare providers and any of the individuals named above, I must notify Skin Dermatology in writing or by contacting the privacy officer at (508) 644-0505.

Client*:______________________________________ Date ______________________________

* Parent or legal guardian if patient is under age 18 or unable to authorize consent.