MetroDerm P.C.
Dermatology, Dermatologic Surgery & Dermatopathology

PATIENT CONSENT FORM

Patient name: _____ Chart #: _____

Consent for Release of Medical and Financial Information to Family Members

I, _____ authorize MetroDerm, P.C. and its staff to release any of my medical and/or financial information to the following person(s):

NONE

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

X _____
Initialed by Patient (or Parent/Guardian, if Patient is a Minor)

Test Result Consent

Please list your preferred contact phone number for pathology and/or laboratory results.

Home _____ Work _____

Cell _____ Other _____

If unable to reach me by phone, I give permission to the physicians and staff of MetroDerm, P.C. to release my test results to my:
Spouse Parent Daughter/Son Other _____

In the event we are unable to reach you, may we leave a detailed message with your results on your answering machine or voice mail at the above listed telephone number?
YES NO

X _____
Initialed by Patient (or Parent/Guardian, if Patient is a Minor)

Consent to Photograph

MetroDerm, P.C. may choose to take medical photographs of me to be part of my medical record for purposes of comparison before and after certain treatments, to track certain types of lesions, or for medical teaching. I agree that photographs may be taken during the procedure and these photographs remain the property of MetroDerm, P.C.

X _____
Initialed by Patient (or Parent/Guardian, if Patient is a Minor)

_____ _____ _____
Patient Signature Date Witness

Johnson Ferry/Perimeter Office - 875 Johnson Ferry Rd., NE, Suite 300 - Atlanta, GA 30342 - Phone: 404-257-9933 - Fax: 404-257-9931
Saint Joseph's Hospital Office - 5667 Peachtree Dunwoody Rd., Suite 180 - Atlanta, GA 30342 - Phone: 404-257-9933 - Fax: 404-257-9931
Paulding/ West Cobb Office - 148 Bill Carruth Parkway, Suite 280 - Hiram, Georgia 30141 - Phone: 678-363-3343 - Fax: 678-363-3380