Medical Information Release Form – HIPAA

Patient Full Name: _____ Date of Birth: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records of examination rendered to me, and claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____

☐ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call: ☐ My Home ☐ My Work ☐ My Cell Number: _____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ other: _____

The best time to reach me is *(day)* _____ between *(time)* _____

_____ _____

Patient or Legal Representative Signature Date

_____ _____

Print Name Relationship (if signed by person other than the patient)

ASCEND DERMATOLOGY

Communications Form

Patient Full Name: _____ Date of Birth: _____

Patient Communications

We provide our patients with the option to participate in our automated or mailing patient communication program. This program includes:

- Keeping up-to-date on our latest dermatology products and services, and
- Cosmetic specials and skin care offers.

We do use a third party to provide these electronic services, the same party that sends our electronic appointment reminders. This party is required by law to sign a contract agreeing to protect the confidentiality of your Protected Health Information (PHI). Ascend Dermatology and its affiliates do not sell, share, or rent any personal identifiable information unless required by law, do not send any other e-mail or communications without your permission, and do not send spam.

Please select your option:

☐ **YES**, I would like to participate in the program

You may opt out of communications at any time by clicking the unsubscribe link in the footer of each e-mail or by replying to a test message with "STOP", or by revoking this authorization in writing. Standard text messaging rates may apply

Please sign below that you agree to allow us to use your information in providing services.

_____ _____

Patient or Legal Representative Signature Date