TOTAL®
DERMATOLOGY

Total Dermatology Patient Contact Information Sheet

Patient Name: _____

DOB: _____

Any physician, staff, employee or representative of Total Dermatology has my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number(s)

_____ I do not authorize Total Skin & Beauty Dermatology Center, PC to discuss my account or medical conditions with others.

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can revoke it by writing to Total Dermatology or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

I have reviewed a copy of the Notice of Privacy Practices.

Patient Signature: _____ Date: _____