APD Adult & Pediatric Dermatology
Medical Cosmetic

Disclosure of Information

This document provides us with guidance on who and how we can share your personal health information, which includes but is not limited to information regarding pathology reports, laboratory tests, scheduling, and business information.

Patient Name: _____

Can we leave a voicemail with benign test results (please circle one): YES NO

PATIENTS 18 & OLDER

Please check one of the following:

☐ I agree to give Adult & Pediatric Dermatology full permission to contact the individuals that I have designated below for the purpose of disclosing information pertinent to my care in the event that they are unable contact me. By my signature below, I agree to hold harmless and waive any liability against Adult & Pediatric Dermatology for the disclosure of information to the individual(s) designated below.

Name	Relationship	Date of Birth	Phone Number

☐ I do not agree to allow Adult & Pediatric Dermatology to disclose any medical information regarding myself to any individuals other than myself.

_____ _____ _____

Print Patient Name/Responsible Party **Signature** Patient/Responsible Party **Date**

MINORS – PATIENTS UNDER 18

We will only disclose personal health information to the legal parent(s) or guardian(s) listed below:

Name	Relationship	Date of Birth	Phone Number