VALLEY DERMATOLOGY SPECIALISTS

HIPAA Release

What is your preferred contact number?

▫ Home _____ ▫ Work _____ ▫ Cell _____

I hereby grant Valley Dermatology Specialists to notify me by telephone of the following:

- ☐ Message to call the office for test results (the actual results will not be left).
- ☐ If the results are benign, a message will be left stating no further treatment will be needed and to keep any advised follow-up as recommended by your physician.

I hereby authorize Valley Dermatology Specialists to disclose my personal medical information pertaining to my diagnosis and/or treatment, biopsy results, medical history, or any other information to myself and those listed below.

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Assisted Living/Long-Term Care Facility Patient: Please list any facility personnel that we are allowed to speak with on your behalf regarding your medical information.

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Do you have a Power of Attorney: ▫ Yes ▫ No (If yes, please list below)

Name: _____ Phone: (___)_____

(If yes, please include a copy of the power attorney paperwork to Valley Dermatology Specialists)

All Patients: The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize the release of this information to other healthcare providers associated with my care to facilitate other healthcare treatment. I further understand that records for medical information from persons not listed above will require specific authorization prior to disclosure of my medical information.

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Signature: _____ **Date:** _____
Printed Name: _____
(if a minor, parent/guardian authorizes and signs on behalf of _____ (**name of minor**)