Peninsula
Dermatologic
Surgery

Medical Information Release Form

(HIPAA Release Form)

Name: ____

Date of Birth**:** ________________________________

Release of Information

Many of our patients allow family members such as their spouse, children or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, please indicate below:

(   ) Spouse ____

(   ) Child(ren) ____

(   ) Caregiver ____

(   ) Other ____

(   ) Information is not 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 you are unable to reach me:

(   ) You may leave a detailed voicemail message (i.e. diagnoses, medication information, etc.)

(   ) Please leave a message asking me to return your call

Patient signature: ____ Date: ______________________