SWINYER-WOSETH DERMATOLOGY

Patient Name:_______________________________________ Date:_____________________

Date of Birth:_______________________________________

WHO MAY WE CONTACT IN CASE OF EMERGENCY:

Name:____

Phone Number:___________________ Relationship:______________________

MEDICAL/FINANCIAL INFORMATION AUTHORIZATION AND RELEASE

The privacy portion of the Health Insurance Portability and Accountability Act (HIPAA) was created for the sole purpose of protecting patient medical records and financial information. In most cases, we are unable to release your medical or financial information without your signed consent, even to your spouse, partner, or parent (if you are over 18 years of age). We urge you to complete this form to allow us to better serve you and protect your private information. Please give us specific and complete information.

I authorize the staff of Swinyer-Woseth Dermatology to release my medical and/or financial information to the following individuals:

SPOUSE/PARTNER:_________________________________ PHONE #:________________

❑MEDICAL ❑FINANCIAL

PARENT/GUARDIAN:________________________________ PHONE#:_________________

❑MEDICAL ❑FINANCIAL

OTHER:_______________________________ PHONE#:_____________________________

❑MEDICAL ❑FINANCIAL

OTHER:_______________________________ PHONE#:_____________________________

❑MEDICAL ❑FINANCIAL

Patient Signature:________________________________ Date:__________________________