



ELKHORN | FREMONT | WAHOO | COLUMBUS
www.skinpc.com

Authorization for Use or Disclosure of Protected Health Information to Skin P.C. Dermatology

Patient Name: _____ DOB: _____
Phone: _____ Address: _____
City: _____ State: _____ Zip: _____

Information May Be Released To: SKIN P.C. DERMATOLOGY

Skin P.C. Dermatology Provider

Address

City, State, Zip

Phone _____ Fax _____

Information Will Be Released From:

Practice/Doctor

Address

City, State, Zip

Phone _____ Fax _____

Please release the following information:

- Progress Notes
- Laboratory Reports
- Other (specify records needed):

- Pathology Reports
- All Records

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold any employee of Skin P.C. Dermatology liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.

Signature of Patient/Legal Guardian Relationship to Patient (self, parent, spouse) Date



TREATMENT CONSENT FORM

Patient Name: _____

I hereby give Skin P.C. my permission to perform the following procedure(s):

The Doctor/PA has fully explained, in terms clear to me, the effects and nature of the procedure(s) to be performed, foreseeable risks involved, and alternative methods of treatment. Lastly, I have been given the opportunity to ask any questions regarding this procedure and these questions have been answered to my satisfaction. I will follow after care instructions.

This consent will be good for one year from the date of signing.

Patient/Legal Guardian (Print Name) _____

Patient/Legal Guardian (Signature) _____

Witness: _____

Date: _____