Dermatology & Skin Cancer Center, P.C.

YOUR PREFERENCE REGARDING MEDICAL INFORMATION RELEASE IN OUR OFFICE

_____ I **DO NOT** wish to authorize the release of any information to any person(s) other than myself.

OR

_____ In addition to the entities in the DSCC HIPAA notice, I authorize Dermatology & Skin Cancer Center to release all information regarding my care at DSCC including diagnoses, treatments and laboratory results to the following person(s):

List anyone (spouses, family members, friends, caregivers etc.) whom we may speak to regarding your medical information: **(If we may speak with your Emergency Contact, please list their names below as well.)**

_______________________	_______________________
(Name)	(Relationship)
_______________________	_______________________
(Name)	(Relationship)
_______________________	_______________________
(Name)	(Relationship)
_______________________	_______________________
(Name)	(Relationship)

May we call your: (Please circle **Y**es or **N**o)		**May we leave messages on:**		**May we send Information via:**	
Home Phone:	**Y** or **N**	Home Answering Machine:	**Y** or **N**	Mail:	**Y** or **N**
Cell Phone:	**Y** or **N**	Cell Phone Voicemail:	**Y** or **N**	E-mail:	**Y** or **N**
Work Phone:	**Y** or **N**	Work Phone Voice Mail:	**Y** or **N**		

____ _______________________

(Signature of Patient or Patient Representative) **(Date)**

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(PRINTED Patient Name)