

Authorization for Verbal Release of Protected Health Information**STANDARD DISCLOSURE**

I authorize Southern Institute of Dermatology to discuss my medical history, diagnosis, treatment, prognosis, and financial, insurance and billing information with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse, as well as, confirmation of any appointment for me to be seen in the office, hospital or other physicians office.

Spouse: _____

Children: _____

Parent(s): _____

Other: _____

NO INFORMATION

I do not authorize release of any verbal information concerning my treatment. I understand that this includes confirmation of appointment dates, times, location and any billing or financial information.

I consent and authorize the release of any test results to be left on my voice mail at

Home Cell Work number Other _____ This authorization will expire at the end of my treatment with Southern Institute of Dermatology unless I revoke the consent prior to that time.

Signature of Patient

Date

Witness

Date