Pediatric Dermatology of North Texas

Young Adult HIPAA Consent

Last Name	First Name	Date of Birth

I understand that medical and/or payment information about my condition and treatment may be released to treating physicians in consultation with Pediatric Dermatology, Pharmacists/Pharmacies and Insurance Providers. However, medical and payment information may NOT be given to <u>other individuals</u> (mothers, fathers, step-parents, grandparents) unless I give my permission by listing below. PLEASE LIST PERSON WHOM YOU WISH OUR OFFICE TO COMMUNICATE WITH.

Patient Signature

X_______________________________________

Date

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Name:____ Relationship:____ Phone number:____	May have the following: Information about my appointments ( ) Information about by my treatment ( ) Information about my test result ( ) Information about my billing/payments ( )
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