BEAVERCREEK DERMATOLOGY
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PATIENT AUTHORIZATION

(Due to the HIPAA laws, we are required to have the following information on record)

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

   Name: ____________________________________ Phone Number: ______________
   Name: ____________________________________ Phone Number: ______________

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name: ____________________________________ Phone Number: ______________
   Name: ____________________________________ Phone Number: ______________

3. Can confidential messages (i.e., appointment reminders, lab and biopsy results) be left on your telephone answering machine or voice mail? YES _____ NO _____

PATIENT NAME: __________________________________ DATE: _______________

PATIENT SIGNATURE: ____
(Guardian if under 18 years of age)

This authorization will remain in effect until revoked by the patient or patient's guardian.