Yale Dermatology Associates, P.C.

Print name of patient: ____

Relationship to Patient: ____
example: self, mother, father, legal guardian, other (specify)

Do you give our office permission to discuss your medical information with family members? Yes No

If yes, please provide us with their names and phone numbers below:

____
Name/relationship phone number

____
Name/relationship phone number

May we leave personal medical information on your:

Answering Machine? Yes No

Cell Phone voice mail? Yes No

May we e-mail personal medical information to you? Yes No

E-Mail address: ____

My signature below indicates I have received and/or reviewed a copy of the Privacy Practice Policy of this office and have agreed to the release of my health information as indicated above.

____
Patient or Responsible Party Signature Date