



**Consent for Treatment /
Authorization for Release of Medication Information**

I authorize Vanguard Dermatology to treat me and/or provide medical services for me, or for the minor in my care.

I authorize Vanguard Dermatology to release information requested by my insurance company or any of its agents. I also authorize Vanguard Dermatology to furnish my primary care physician, referring physician or other treating medical professional any and all information that may be requested regarding my physical or mental condition, treatment rendered by my physician at Vanguard Dermatology, or any records or results. This authorization shall remain in force until revoked in writing by the undersigned.

Signed (Patient or Responsible Party)

_____ Date _____

Staff Witness Name and Signature

_____ Date _____

Consent for Communication of Information

In addition to release of information as authorized above (Authorization for Release of Medical Information), and in the interest of confidentiality and compliance with HIPAA (Health Insurance Portability and Accountability Act), I authorize the release of information as it pertains to my care to the following individuals:

Name _____ Relationship _____ Tel# _____
Name _____ Relationship _____ Tel# _____

For the purpose of communicating test results, prescription refill requests, and other information, please provide us with acceptable ways of reaching you:

Vanguard Dermatology may leave messages only: (please check all that apply)

- On my home answering machine # _____
- On my cell phone voicemail # _____

I have the right to revoke and change my consent options as listed above. When circumstances change regarding me response, In order to make changes to my communication options, I will submit written changes, revocations, limitations, and restrictions to Vanguard Dermatology, at main office address. Without a written letter that makes changes to the acceptable methods of communicating information, Vanguard Dermatology Doctors nor Staff will not be held liable for leaving messages or test results on the methods of communication listed above.

Signed (Patient or Responsible Party)

_____ Date _____

Internal use only:

If the Patient or Responsible Party refused to sign any of the above acknowledgements, please document the date and time the patient was presented with the above material and sign below:

Information presented on (date) _____ Time _____

Staff Name _____ Signature _____