INDIGO DERMATOLOGY HEALTH INFORMATION RELEASE FORM

In order to assist you in receiving your health information from Indigo Dermatology, please complete this form.

I authorize the persons listed below to have access to any and all of my health information. Indigo Dermatology is permitted to:

PLEASE CHOOSE ONE

- o Share my medical information with the following people, including HIV, drug/alcohol abuse and psychiatric records, as well as test results and information disclosed during office visits
- o Share medical information including test results and information disclosed during office visits **not including**, HIV, drug/alcohol abuse and psychiatric records

Persons authorized to receive my medical information are:
(PLEASE DO NOT LEAVE BLANK)

FULL NAME	PHONE #
_____	_____
_____	_____
_____	_____

We typically deliver benign biopsy results via phone call. If you do not pick up the phone call, we request permission to leave your results on voicemail.

You may notify me or the parties listed above with normal test results, appointment reminders and other information regarding my health information as follows:

- o Message on cell voicemail_____ Phone Number: _____
- o Message on Home Phone/# on file _____ Phone Number: _____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ _____
Patient – Print Name Witness–Print

_____ _____
Patient – Signature Witness – Signature

_____ _____
Patient – Date of Birth QMC Patient Account # Date