MAIN LINE DERMATOLOGY
DERMATOLOGY, DERMATOLOGIC SURGERY, COSMETIC DERMATOLOGY AND MOHS MICROGRAPHIC SURGERY www.mainlinederm.com
MICHAEL D. DAMIANO, MD SCOTT N. SCHAFRANK, MD JAMEA ELIZABETH CAMPBELL, MD
JON H. MEYERLE, MD TATYANA R. HUMPHREYS, MD ALAN J. HIMMELSBACH, CRNP

AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name: _____ Date of Birth _____

The physicians and/or staff of Main Line Dermatology may need to contact you in reference to an appointment, scheduled surgery, biopsy and/or lab results, or in order to schedule further treatment. In accordance with privacy laws we will not disclose Patient Protected Health Information (PHI) to anyone other than the patient without written authorization (except where permitted per our Notice of Privacy Practices for Treatment, Payments and Health Care Operations).

The following statements authorize Main Line Dermatology to release medical information. Please list the phone numbers authorized by you to leave detailed messages and list the individuals authorized to receive medical information. You may revoke these authorizations in writing at any time.

I **AUTHORIZE** Main Line Dermatology to leave a **detailed message** about my health care, test results and/or need for future treatment at the following telephone numbers:

Cell Phone: _____

Home Phone: _____

☐ I **DO NOT** authorize Main Line Dermatology to leave a detailed message

I **AUTHORIZE** Main Line Dermatology to disclose any and all medical information to the following individuals.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

By signing below, you are authorizing Main Line Dermatology to leave detailed medical information at the above phone numbers and allowing Main Line Dermatology to speak to the above individuals regarding your treatment.

_____

Signature of Patient/ Parent or Guardian Date