DERMATOLOGY ASSOCIATES, P.A.

I,_____, hereby authorize Dermatology Associates, P.A. (Falls L. Harris, M.D., Charles S. West, Jr., M.D., Joseph M. Catanzaro, M.D., Leslie Howard Poinsette, M.D., Matthew E. Bryan, M.D., Joel C. Phillips, M.D., W. Justin McCrary, M.D., and Allyson N. Cook, PA-C) and staff to discuss with the following people information concerning my health, treatment, billing, and/or insurance information.

- ❑ Spouse Name: _____
- ❑ Parent/Legal Guardian Name: _____
- ❑ Significant Other Name: _____
- ❑ Any Specified Person Name: _____

Restrictions:

- ❑ No Restrictions
- ❑ Do not discuss any information regarding my health including appointment time, test/lab/pathology results, pre and post surgery instructions, billing/insurance, or account information with anyone except me.
- ❑ Only discuss my appointment time with the above named individual(s).
- ❑ Only discuss my test/lab/pathology results with the above named individual(s).
- ❑ Only discuss my pre and/or post surgery instructions with the above named individual(s).
- ❑ Only discuss issues concerning my account, including insurance, and/or billing with the above named individual(s).

❑ Yes
❑ No **Messages may be left on my answering machine regarding the above.**

I understand I may terminate this consent any time by giving written notice to Dermatology Associates, P.A. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signed _____ Date _____

Witness _____ Date _____

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