MT. PLEASANT DERMATOLOGY, LLC

PERMISSION FOR VERBAL & ELECTRONIC COMMUNICATION

Patient Name _____ Date of Birth _____

I am authorizing Mt. Pleasant Dermatology, their physicians, nurses, and other personnel to discuss my medical information, in person or by phone, with the following individuals listed below. I understand that if I choose not to list anyone on this form that my health information will not be shared with anyone other than myself. **This document does not authorize the release of any written health information.**

Unless indicated otherwise, this authorization includes disclosure of medical information to include office visits, lab/pathology findings, and treatment plans.

If at any time I wish to revoke any authorizations included on this form, I must contact the office, in writing and signed by me.

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medical conditions you wish to exclude from verbal communications

_____

Permission for Communications (Please initial for approval)

_____ I authorize Mt. Pleasant Dermatology to leave a confidential voice mail message regarding upcoming appointments. **I understand that no test results will be left on voice mails.** Please list a number below where you wish to receive voice mails.

_____ Home ☐ Cell ☐ Work ☐ Other ☐

_____ I authorize Mt. Pleasant Dermatology to use my patient portal to communicate with me regarding my health, medication refills, or other questions I may have.

_____ I authorize Mt. Pleasant Dermatology to use text/email for appointment reminders.

Prescription Medication Consent

The providers at Mt. Pleasant Dermatology use an electronic medical record system that allows electronic prescribing of medications. This system also has the ability to access any other medication history prescribed to you in the past from other providers. By signing below I indicate that Mt. Pleasant Dermatology may access my medication history.

THIS FORM DOES NOT EXPIRE UNLESS REVOKED OR UPDATED.

_____ _____

Signature of Patient or Responsible Party **Date**