SKIN SURGERY CENTER
SKIN CANCER SPECIALISTS

CONTACT CONSENT

If requested, I, _____, authorize my information to be shared with:

(Patient Name)

1. Name _____ Phone _____ Relationship _____
2. Name _____ Phone _____ Relationship _____
3. Name _____ Phone: _____ Relationship _____

****NO ONE** _____

Regarding the **initialed** items below, I understand that by signing this form only the person(s) designated above are allowed to obtain my information and they are **only** allowed to obtain information regarding the items that I have designated below. By **initialing** beside **"ALL INFORMATION"** I understand that the person(s) listed above will be granted access to obtain all of my medical and personal information that the office of Skin Surgery Center has on file. I understand that this written authorization will remain in my permanent record and will not change at any time unless I issue a written consent to discontinue and/or change this authorization.

_____ APPOINTMENT DATES/TIMES
_____ TEST RESULTS
_____ INSURANCE INFORMATION
_____ **ALL INFORMATION**
_____ OTHER: _____

Authorization to leave medical information by alternate means

Please check all that apply:

- ☐ May send personal medical information via an **e-mail message** to the address provided on my Registration Form. I understand that e-mail may not be a secure means of communication.

- ☐ May leave a detailed message on voicemail at the **following** phone number(s) provided on my Registration Form:
  ☐ Home ☐ Work ☐ Mobile

- ☐ May leave a detailed message at a different location, with a spouse/partner or with another family member:

  Name:_____ Relationship:_____ Phone:_____

Signature: _____ Today's Date: _____/_____/_____

(Patient or Responsible Party)