Dermatology
Surgical & Medical Group

Permission to Verbally Discuss Protected Health Information

Patient Name _____ Date of Birth _____

Patient Street Address _____ City _____ State _____ Zip Code _____

Preferred Phone Number _____ Work Phone Number (optional) _____

☐ **I give permission to Dermatology Surgical & Medical Group to VERBALLY discuss information about me with:**

Name _____ Relationship _____

Home/Cell Phone _____ Work Phone _____

I give permission to discuss the following protected health information (check all boxes that apply):

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral heath information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Billing and payment information
- ☐ Other (describe):_____

I have the right to change or revoke my permission in writing at any time except where Dermatology Surgical & Medical Group has already made disclosures in trust of this original request. **I understand that I must complete a new form or notify Dermatology Surgical & Medical Group in writing if I want to change or revoke any of the permissions indicated above.**

_____ _____

Signature of Patient/Authorized Representative **Date**

(If authorized representative, please sign and attach copies of supporting legal documentation)

NOTE: This is **not** an authorization to release medical records. If you would like to obtain a copy of your medical records, you will need to complete a **Dermatology Surgical & Medical Group** Authorization to Release Protected Health Information form.

1661 Soquel Drive Suite E, Santa Cruz, CA 95065
T: 831-476-2444 F: 831-476-0705