Dermatology, Laser & Vein Specialists
OF THE CAROLINAS

FRIENDS AND FAMILY INFORMATION FORM

Patient Information:

Name: _____ **Date of Birth:**_____

Dermatology, Laser & Vein Specialists of the Carolinas is authorized to release protected health information about the above named patient to the person(s) listed below and in the methods selected.

Individual(s) to Receive Information: (e.g.- spouse or family members) *list anyone that you approve to receive information		**Check Information Allowed:** Financial	Medical
1._____	Phone #:_____	_____	_____
2._____	Phone #:_____	_____	_____
3._____	Phone #:_____	_____	_____
*For email communications *(*always use encrypted email for correspondence regarding personal health information)* Email Address:_____		_____	_____

Appointment Reminders: please check the type you would like to receive from our office.

Telephone/Voicemail: _____ Text Message: _____ (your cell phone carrier may charge you for these messages)

Patient Rights:

I have the right to revoke this authorization at any time.
I may inspect or copy the protected health information to be disclosed as described in this document.
Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
I understand that released information may include a communicable disease diagnosis such as HIV.

This authorization shall be in effect until the termination of your patient relationship with Dermatology, Laser & Vein Specialists of the Carolinas.

_____ _____
Signature of Patient or Patient Representative Date

_____
Description of Patient Representative's Authority* (if applicable) ***PLEASE ATTACH NECESSARY DOCUMENTATION**