CENTER FOR DERMATOLOGY
ERIK B. HURST, MD

HIPAA PRIVACY NOTICE

I acknowledge receipt of the Center for Dermatology's HIPAA Privacy Notice.

Signature _____Date _____

Printed Name of Patient _____

If you are signing as the patient's representative, print your name _____
Describe your authority _____

I give permission for tests results and medical information to be released to
the following representative _____
His/ her phone number is _____

I give permission for the following person(s) to receive test results and medical information
_____His/ her phone number is _____

Patient Signature _____

Wittness _____

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