

Dermatology And Laser Center
4201 Camp Bowie Blvd
Fort Worth, TX 76107

RELEASE OF INFORMATION STATEMENT / PRIVACY NOTICE

Patient Name: _____ Date ___ / ___ / ___ E-mail: _____

Referred By: _____ Primary Care Physician: _____

Phone() _____

EMERGENCY CONTACT INFORMATION

In case of an Emergency, who should be notified? _____ Phone() _____

Relationship to Patient: _____

Do you give our office permission to discuss your medical information with family Members? Yes ___ No ___

If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____ Phone() _____

Name: _____ Relationship: _____ Phone() _____

May we leave personal medical information on your answering machine or cell phone? Yes ___ No ___

May we e-mail personal information to you? Yes ___ No ___

RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have received and/or reviewed a copy of my Physician's Notice of Uses and Disclosures of Medical information, as well as Office Policies for Dermatology and Laser Center of Ft. Worth.

Patient or Responsible Party Signature _____ Date ___ / ___ / ___