SCHOLES DERMATOLOGY

HIPAA REGISTRATION FORM
Release of Information

Full Name_____ Gender- Male_____ Female_____
Mailing Address_____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Home Phone #:_____ Cell#:_____
SSN #_____ Email _____
Marital Status: Married_____ Single_____ Widowed_____ Divorced_____
Place of Employment/Occupation: _____ Phone:_____

May we leave medical Information about you on your answering machine? Yes or No

May we discuss your medical information with anyone other than you? Yes or No

Names of family Members: _____

Signature: _____ Date: _____

Insurance Policy Holder or Responsible Party Information

Name: _____ DOB: _____
Relationship to patient: _____ Social Security #:_____
Address if different than above: _____

Were you referred to our office? Yes or No
If yes, Physicians Name: _____ Phone #:_____

In order to provide you with the best patient care possible, your doctor may discuss your case or transfer all or part of your medical records to a consulting physician or your referring physician. Your signature also authorizes Scholes Dermatology to release carrier information regarding care to your insurance company for the purpose of billing.

This Release refers to all past, current and future medical records