563-A Neff Avenue,
Harrisonburg, VA 22801
Phone: 540-434-1756
Fax: 540-434-1840

HIPAA RELEASE FORM:

I hereby give my permission to disclose personal information about my treatment to the following individuals:
(Example: Spouse, parent/legal guardian, friend, etc.) **We may only give information to listed individuals (including parents & spouses). If no one is listed Access Dermatology CANNOT give any information about you.**

Name:_____Phone: _____ Relationship:_____

Name:_____ Phone#: _____ Relationship: _____

____ YES, I acknowledge that anyone not listed above will be unable to communicate with Access Dermatology on my (or my child's) behalf. **WE MUST BE ABLE TO COMMUNICATE WITH THE ACCOUNT GUARANTOR REGARDING BILLING MATTERS**

*_____ _____
Patient Signature **Date**
(Or Parent/Legal Guardian of Minor)

May we leave personal medical information on your home answering machine or cell phone voicemail?
___YES ___NO
May we contact you about upcoming appointments or follow-up reminders via email and/or voicemail?
___YES ___NO

YOUR PREFERRED CONTACT METHOD for RECALLS/FOLLOW-UPS:
_____**EMAIL** _____**PHONE** _____**US MAIL**

I have read and agree to the Notice of Privacy Practices provided to me by Access Dermatology, PC.

*_____ _____
Patient Signature **Date**
(Or Parent/Legal Guardian of minor)

I have read and agree to the Financial Policy provided to me by Access Dermatology, PC.

*_____ _____
Patient Signature **Date**
(Or Parent/Legal Guardian of minor)

AUTHORIZATION AND CONSENT TO TREAT

I, the undersigned, authorize Mary Mather, MD to provide medical care to me or my minor dependent. I, the undersigned, authorize release of any medical information or other information necessary to process insurance claims for myself or my minor dependent. I, the undersigned, request that payment of authorized Medicare and/or other insurance benefits be made, for me or on my behalf, to Access Dermatology, PC, for any services furnished by that physician/provider. I authorize any holder of medical information about me to release to my insurance carrier and/or the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits are payable for related services.

*_____ _____
Patient Signature **Date**
(Or Parent/Legal Guardian of minor)

Print Patient Name _____ **DOB** _____