The Skin Group, PLLC
Protected Health Information Disclosure, Consent to Leave Messages and Emergency Contact

I give The Skin Group, PLLC permission to disclose My Protected Health Information to:

Patient Name: ____________________ DOB: ______________ Phone: ______________

Spouse/Significant Other: ____________________ Phone: ______________

Parent/Guardian: ____________________ Phone: ______________

Roomate: ____________________ Phone: ______________

Other: ____________________ Phone: ______________

Children: ____________________ Phone: ______________

____________________ Phone: ______________

I give The Skin Group, PLLC permission to leave messages regarding my bill, credit card information, medical care, tests or lab results on an answering machine, voice mail or with an individual at the following number:

Home Phone Voice Mail: ____________________

Cell Phone Voice Mail: ____________________

Work Phone Voice Mail: ____________________

Emergency Contact:

Name of Contact: ____________________

Relationship to Patient: ____________________

Phone Number: ____________________