Privacy Statement

You have the right to review our privacy practice, request restrictions and revoke consent in writing after you have received our privacy notice. Signing below signifies that you have had the opportunity to view the privacy policy of our office.

By signing below you acknowledge you have read, understand and agree to the Atlas Dermatology Financial Policy and our Notice of Privacy Practices.

By signing below, I authorize the release of medical information to my primary care or referring physicians, to consultants, if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

Printed Patient Name: _____

Signature of Patient/Insured/Guardian:_____Date:_____

Printed Name of Patient/Insured/Guardian:_____Date:_____

Signature of Office Representative:_____Date:_____

Please list the names of the persons to whom we may disclose the patient's private health information and state how the individual is related to the patient:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient DOB:_____

Patient Account #:_____