INTEGRATED
DERMATOLOGY

HIPAA Release of Information

Messages regarding office appointments may be left on my:

☐ Cell phone ☐ Home phone ☐Work phone

☐ Email ☐ Sent as text to cell

Messages regarding information related to my care may be left on my:

☐ Cell phone ☐ Home phone ☐ Email

okay to discuss my health information with:

_____

_____

_____

Please let us know if someone else is allowed to bring your child to be seen here at Integrated Dermatology of Waterbury. This will authorize the following people to make all medical decisions on the parent(s) behalf. If someone that is not the parent or not listed on this form comes with your child they will not be able to be seen without written consent.

Name:_____Relationship: _____

Name:_____Relationship: _____

This HIPPA Release of Information was signed by:

_____
Printed Name – Patient or Representative

_____ _____
Signature Date

Relationship to Patient
(if other than patient):_____

_____

Madison Location
1343 Boston Post Road, Suite 101, Madison, CT 06443
Phone: (860) 259-4037 • Fax: (860) 644-0285

Waterbury Location
1078 W Main St, Waterbury, CT 06708
Phone: (203)-408-2730 • Fax: (203) 757-6300