ASCS

ASSOCIATED SKIN CARE SPECIALISTS

Patient Label

Authorization for Verbal Communication of Protected Health Information:

The number provided at registration is the **primary** number you give consent for ASCS to contact you and/or leave a message regarding your appointments, test(s) and biopsy results. List any alternate phone number(s) below that you give consent to leave a message.

Phone: _____ (Work, Cell, Home)

Phone: _____ (Work, Cell, Home)

Email: _____

☐ **I authorize ASCS to possibly use images/video of my procedure experience for media purposes:**

☐ **I authorize ASCS to discuss ALL aspects of my protected health information with those individuals listed:**

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

For patients 65 years of age or older ONLY: Do you have a health care proxy or emergency contact in the event you are unable to make your own medical decisions? (please circle)

No

Yes If yes, please list name and phone number:

Name_____ Relationship_____ Phone_____

Signature Patient/Other: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

 This will expire in one year from date of signature unless revoked in writing by the patient or guardian.