

DALLAS CENTER FOR DERMATOLOGY AND AESTHETICS

8201 PRESTON RD. SUITE 350
DALLAS, TX 75225

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CONFIDENTIAL INFORMATION AGREEMENT

Please list the family members or other persons, if any, with whom we may discuss your general medical condition and/or your diagnosis:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Please list the family members or other persons, if any, with whom we may discuss your medical condition **ONLY IN AN EMERGENCY.**

 Same as above

 No one

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Please print the telephone number, if any, where you want to receive calls about appointments, lab and test results, billing and insurance inquiries, or other health care information.

() _____ - _____

May confidential messages (appointment reminders, lab & test results, billing & insurance inquiries) be left on the answering machine or voicemail at the number given above?

YES _____ NO _____

If you do not have an answering machine or voice mail, may we leave a confidential message? (example: "Would you please ask Mr/Mrs. Smith to call Mary at Dr. Jones' office?")

I understand that this agreement remains in effect until revoked by me in writing. If I revoke my consent, such revocation will not affect any actions that Dallas Center for Dermatology and Aesthetics took before receiving my revocation.

PATIENT NAME

GUARDIAN IF UNDER 18 YEARS

PATIENT/GUARDIAN SIGNATURE

DATE