# Associates in Dermatology of Traverse City - Patient Information

Patient Last Name**:** _____First: _____M. I.:_____

Mailing Address: _____

City/State: _____ Zip Code: _____

Primary Phone: _____ Cell/Home/Work Date of Birth: _____

Alternate Phone: _____ Cell/Home/Work Sex: ☐ Female ☐ Male

Email Address: _____

Responsible Party: ☐ Self (If over 18) ☐ Other _____ Relationship:_____

Responsible Party Address (If different than Patient): _____

Name of Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____

**I authorize Associates in Dermatology of Traverse City, PC to evaluate and administer medical care. I authorize the release of any medical information concerning my treatment to my insurance company or companies (for billing). I understand and agree, regardless of my insurance status, that I am ultimately responsible for the balance of my account. I will notify you of any changes in my health status, demographic or insurance information.**

_____

Signature of Patient/Responsible Signature Date

# HIPAA Release Form

By listing the persons below, I am authorizing any employee of Associates in Dermatology of Traverse City, to release information contained in my patient records to the individuals listed below, only under the conditions listed below:

☐ Do not release any information to anyone.

☐ I authorize information to be released to (PLEASE PRINT NAMES & RELATIONSHIPS):

_____

_____

_____

*Without expressed written revocation this authorization will remain in effect from date of signature.*

**I acknowledge that I have been offered a copy of Associates in Dermatology of Traverse City's Notice of Privacy Practices explaining my rights and permitted uses and disclosures with regard to my protected health information.**

_____ _____

Signature of Patient/ Patient Representative Date