SCSPHYSICIANS
skin care specialty physicians

Receipt of Notice of Private Practices (HIPAA)

I have received, read and agree with the Notice of Privacy Practices and the Office and Financial Policies.

☐ I don't want anyone else to receive my medical information.

☐ I give consent to release all of my past, present and future medical information to the below listed names:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

☐ **I agree to receiving confirmations through text messaging.**

Primary Care Physician: _____

Emergency Contact Information

Name:_____ Relationship:_____

Telephone: (_____) _____ - _____

Patient Signature:_____ Date: _____

Patient Name (Printed):_____

Patient E-MAIL: _____