SEEBERGER DERMATOLOGY

Consent for Verbal Release of Information

Preferred Number	Type (please circle)	Leave Detailed Message (please circle)	Leave Detail Lab/Test Result (please circle)
Primary Phone #:	Home/Work/Cell	Yes/No	Yes/No
Secondary Phone #:	Home/Work/Cell	Yes/No	Yes/No

Please note the voice mail message must have an identifying message to confirm these are your numbers for example; "You have reached John Doe". If the message does not identify your name, we will be unable to leave a detailed message even if you opted us to do so.
I hereby give permission to Seeberger Dermatology, LLC to notify me by telephone, text, and/or email for the following:

- ☐ Appointment Reminders
- ☐ A message to call the office for test results (actual results will not be left)
- ☐ Benign results, a message will be left, stating no further treatment would be needed and to keep any advised follow up as recommended by the provider.

I authorize Seeberger Dermatology, LLC to disclose my medical information pertaining to my diagnosis and/or treatment, lab results, medical history, or any other such related information to myself and those listed below.

Name	Phone Number	Relationship

Assisted living/Long term care facility residents:

Power of Attorney Name — Relationship to Patient

Telephone Number — Date of POA Received

*Please note the POA is only valid if we have the paperwork scanned into the patient's medical record

Please list any facility personnel we can speak with on your behalf regarding your medical information:

Name — Telephone Number — Relationship

I understand that this consent is valid until it is revoked by me and applies to information about me obtained through all Seeberger Dermatology, LLC locations and providers. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the Seeberger Dermatology, LLC. I also understand that I will not be able to revoke this consent in cases where the provider has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the provider's office.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____