DERMATOLOGY ASSOCIATES, INC

1514 Amherst Street, Winchester, VA 22601
(540) 667-4499

Patient name:_____Date of Birth:_____

I acknowledge receipt of the Dermatology Associates, Inc. HIPAA Privacy Notice.

Signature of Patient or Representative:_____Date:_____
If not patient mark one: ❑ Parent ❑ Guardian ❑ POA ❑ *Responsible Party

Printed name of Representative:_____

Authorization and consent to share test results, medical information, billing information, and/or schedule/cancel appointments on my behalf is given to the representatives listed below:

Printed Name	Phone Number	Relationship to patient

Signature of Patient or Representative:_____Date:_____
If not patient mark one: ❑ Parent ❑ Guardian ❑ POA ❑ *Responsible Party

Printed name of Representative:_____

Witness Signature:_____