



**CONSENT FOR TREATMENT:** I authorize Knott Street Dermatology and its personnel to provide ongoing medical care, treatment and procedures (skin biopsies, routine surgical procedures etc.) as ordered by the physicians and/or other health care providers. Most tissue and cultures are sent to outside laboratories, if your insurance carrier requires a specific facility, please let our staff know at the time service is rendered. I acknowledge that no guarantee can or will be made as to the results of the care, treatment and medication prescribed.

**CONSENT TO RELEASE OF INFORMATION:** I authorize Knott Street Dermatology to release to my insurance carrier(s)– including Medicare, Medicaid and any other reimbursing agency–information about my identity, treatment, diagnosis, prognosis and/or services rendered (including drug and alcohol abuse treatment, mental health treatment; diagnosis and/or treatment of HIV, AIDS, AIDS-related illness or sexually transmitted disease) as permitted by state and federal law which may be required or requested, thus releasing Knott Street Dermatology from any liability for furnishing such information. I understand information may be released through electronic or paper media.

**NOTICE OF HEALTH INFORMATION PRACTICES:** I acknowledge that the Notice of Privacy Practices is on file and I may access it at will.

**PATIENT INFORMATION:**

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
DOB \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State Zip \_\_\_\_\_  
Home # \_\_\_\_\_ Cellular # \_\_\_\_\_ Work # \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Email Address \_\_\_\_\_ Preferred Contact # \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_  
Pharmacy Name and Address \_\_\_\_\_

**GUARANTOR/SPOUSE/PARENT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
DOB \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Street Address (if different) \_\_\_\_\_  
City, State Zip \_\_\_\_\_  
Contact # \_\_\_\_\_

**EMERGENCY CONTACT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Contact # \_\_\_\_\_

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient or Legally Authorized Representative**

\_\_\_\_\_  
**Printed Name and relationship to patient, if not signed by patient**