Dermatology Associates of South Jersey, LLC

112 White Horse Pike
Haddon Heights, NJ 08035
856-546-5353, fax: 856-546-8711

Patient Name: _____ DOB: _____

I understand that Dermatology Associates of South Jersey, LLC maintains my personal records, medical history, symptoms, examinations and test results as part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

RELEASE OF INFORMATION

( ) I authorize the release of information including diagnosis, records, laboratory values/results, biopsies, prescribed medications, treatment plan, examination rendered, and claim information and billing. This information may be released to:

( )Spouse/Partner_____

( ) Child(ren)_____

( ) Other_____

( ) Information is NOT to be released to anyone.

( ) Check if ok to leave a message on your answering machine at home or cell phone.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date:_____