CHARLESTON
DERMATOLOGY

PATIENT CONTACT INFORMATION SHEET

Patient Name: _____

Social Security Number: _____-____-_____

Any physician, staff, employee or representative of Charleston Dermatology, PC has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)

I authorize Charleston Dermatology, PC to contact me via:

□ Phone _____

□ Text Message _____

□ Email _____

Please check below where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) blank if you do not wish to receive voice mails.

□ Home _____ □ Cell _____ □ Other _____