Dermatology Associates, Inc.

1514 Amherst Street • Winchester, VA 22601

(540) 667-4499

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

Signature:_____ Date:_____

Printed Name of Patient:_____

If you are signing as the patient's representative:
Print Your Name: _____

Describe your authority:_____

I give permission for tests results and medical information to be released to the following representatives:

Printed Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Patient or Responsible Party Signature Date

Witness Signature:_____