CRAIG AUSTIN DERMATOLOGY, P.C.
200 WESTAGE BUSINESS CENTER DRIVE, SUITE 231
FISHKILL, NY 12524

Patient Name ___________________________________ **Date** ___________________

*****<u>**Release of Information**</u>: I authorize the release of medical or other information necessary to process my claims.

*****<u>**Authorization of Payment**</u>: I authorize payment of medical benefits to the physician or supplier for services rendered. I also request payment of government benefits, if applicable, to myself or the party who accepts assignment.

*****<u>**Financial Responsibility:**</u> I understand that certain charges may not be covered by my medical insurance and I am financially responsible for all charges incurred including co-payments and deductibles.

<u>**Communication Consent:**</u>

Due to the new Government HIPAA Regulations, your personal medical records must be securely maintained. Therefore, we request that you indicate ALL names of persons authorized to receive medical information from the staff OTHER THAN physicians or other medical personnel.
For example: parents, spouse, and/or children.

1. ____
2. ____
3. ____
4. ____
5. ____

EMERGENCY CONTACT NAME AND NUMBER:

____
Name Number

I have read and agree to all of the above

____
Signature Date