

**Dr. Alexander Zemtsov • Dr. Lisa Wilson**

**Laine ELam, P.A.**

*Certified by the American Boards of Dermatology and Quality Assurance*

830 Sim Hodgin Pkwy. • Richmond, Indiana 47374

765-939-7664 • 1-800-450-4548

2525 West University Avenue, Suite 402 • Muncie, Indiana 47303

765-747-6090 • Fax 765-747-5069 • 1-800-450-4548

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**RELEASE OF INFORMATION**

Patient's Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

I hereby give my consent for University Dermatology Center to discuss my condition, results of tests, as well as medical examinations, with:

\_\_\_\_\_/\_\_\_\_\_  
Name Relationship to Patient

\_\_\_\_\_/\_\_\_\_\_  
Name Relationship to Patient

\_\_\_\_\_/\_\_\_\_\_  
Name Relationship to Patient

\_\_\_\_\_/\_\_\_\_\_  
Name Relationship to Patient

Please initial if we may contact you by mail with issues concerning your health \_\_\_\_\_

Please initial if we may leave messages regarding appointments on your answering machine \_\_\_\_\_

Please initial if we may leave messages regarding test results on your answering machine \_\_\_\_\_

Please initial if we may leave messages regarding medications on your answering machine \_\_\_\_\_

Please initial if we may leave messages regarding procedures or referrals on your answering machine \_\_\_\_\_

Please initial if we may contact your employer concerning insurance denials and additional information for filing a medical claim \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date