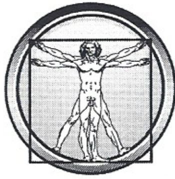

University Dermatology Center

Dr. Alexander Zemtsov • Dr. Lisa Wilson
Laine Elam, PA-C • Robert Muller PA-C
Certified by the American Boards of Dermatology and Quality Assurance
830 Sim Hodgin Pkwy. • Richmond, Indiana 47374
765-939-7664 • 1-800-450-4548
3500 W. Purdue Ave • Muncie, Indiana 47304
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