Welcome to Parkland Dermatology and Cosmetic Surgery

AUTHORIZATION & AGREEMENTS OF MEDICAL TREATMENT

CONSENT FOR EXAMINATION: I understand that an examination will be necessary and I consent to the partial or complete examination as part of my medical care. I understand that the examination findings will be provided to me with recommendations. The responsibility for any follow-up examination to check abnormalities found and treated, lies with me and not Parkland Dermatology and Cosmetic Surgery, or assistants. I hereby release my examiner from all responsibility in connection with the examination.

Initial _____

CONSENT FOR TREATMENT: I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments, including biopsies and cryosurgery, that may be considered advisable or necessary in the judgment of Parkland Dermatology and Cosmetic Surgery. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments. Initial _____

In order to fulfill our commitment to be as accessible as possible to our patients, we seek your permission to communicate with you via the most convenient means possible, using the communication tools you use every day.

CONSENT FOR ELECTRONIC COMMUNICATION: I hereby consent and state my preference to have my physician and other staff at Parkland Dermatology and Cosmetic Surgery communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing statements. I understand that email and standard SMS messaging are not secure methods of communication. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

_____ **PATIENT EMAIL ADDRESS** Initial _____

CONSENT FOR INFORMATION LEFT ON VOICEMAIL: I hereby consent that telephone messages regarding my appointments, prescription renewals, lab results and all protected health information may be left for me on my voicemail and/or answering machine at the following phone numbers:

(_____)_____**HOME / WORK / CELL** Initial _____

Parent or legal guardian must sign for patients less than 18 years old:
I authorize for Parkland Dermatology and Cosmetic Sugery to see and treat my child and/or dependent, with or without my presence.

_____ _____ _____

SIGNATURE PATIENT OR REPRESENTATIVE **DOB** **TODAY'S DATE**

_____

PRINTED NAME PATIENT OR REPRESENTATIVE **RELATIONSHIP TO PATIENT**