Peak Dermatology

2009 W. Littleton Blvd. Suite 100
Littleton, CO 80120

Acknowledgement of Receipt of Notice of Privacy Practices and Office Policies

I hereby acknowledge receipt of the Office Policies and Notice of Privacy Practices of Peak Dermatology. I have reviewed, understand and agree to the administrative rules, privacy, office and financial policies of Peak Dermatology.

____
Patient Name (please print)

______________________________ ______________________
Signature of Patient or Legal Representative Date

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Relationship to Patient (if applicable)

Information Release

I hereby give permission for Peak Dermatology to leave a message at my phone number in regards to my dermatology care, including Lab and/or Pathology results.

Primary Phone Number: ______________________________

Alternate Number: ______________________________

Extended Release Authorization

Provide any person (spouse, family member, caretaker) who you authorize to receive information regarding your care, appointments or billing below:

______________________________ ______________________
Name Relationship

______________________________ ______________________
Name Relationship

______________________________ ______________________
Signature of Patient or Legal Representative Date