Premier Dermatology 2026 N. Beech Daly Rd Dearborn Heights, MI 48127
Phone :(313) 359-7900 FAX:(313) 359-7800

Premier Dermatology General Consent for Treatment

1. I hereby do voluntarily consent to such care including routine procedures and other treatment by Premier Dermatology's professionals and their assistants, appointees, or consultants, as is necessary in their judgment.
2. I am aware that the practices of medicine, surgery, and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments or examination at the Premier Dermatology clinic.
3. I understand that for certain procedures deemed necessary by my physician, I will be required to sign a special consent form. Further, if I don't fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to question the appropriate healthcare professionals.
4. I understand that Premier Dermatology shall not be responsible or liable for the loss of or damage to any personal property.
5. I authorize the release to any party responsible for my care, such information from my records as is required in order for Premier Dermatology and all entities providing services to obtain payment. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when the payment or reimbursement is received.

I have read this form and my questions have been adequately answered and I certify that I understand its contents.

_____ Date: _____
Patient's Signature (May sign "X" if physical condition prevents signature)

_____ Date: _____
Signature of Parent or Guardian
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Consent to Share Personal Health Information

I give my permission for the following people to have unlimited access to my medical records, appointment information, and billing information at Premier Dermatology. I understand the following people will be able to make and cancel appointments for me, and discuss billing questions and my medical information with the staff of Premier Dermatology.

I also understand that at any time I can remove any of the names from the list in writing, and they will no longer have access to my information.

Name	Relationship	Phone number

_____ _____ _____
Patient's Signature Print Name Date

_____ _____ _____
Witness' Signature Witness' Name Date