

# SKINRITUAL

aesthetic clinic

## Release of Patient Information

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Preferred contact phone number:

Cell: \_\_\_\_\_

Home: \_\_\_\_\_

Okay to leave detailed messages on voicemail? (Please circle)    **Yes**                      **No**

### Appointment Reminders & Messages:

- I give my consent to receive messages on my cell phone via text for appointment reminders. These messages may contain office promotions.
- I decline cell phone text messages

### Email Communication:

- I give my consent for Skin Ritual and/or Desert Sky Dermatology to communicate with me via email regarding my care to the following email address: \_\_\_\_\_
- I decline email communication

\*Reminder: Appointments cannot be made, cancelled, or rescheduled through Instagram or any other social media platform.

### Okay to discuss my health or billing information with:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

- Do not discuss my information with anyone**

**Consent to Download Medications via Surescripts:** I authorize Skin Ritual and Desert Sky Dermatology to view all available prescription history from any external source. I am aware that Skin Ritual uses a secure connection to Surescripts to send and receive most prescriptions from this office.

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I have completed and understand the information detailed on this form.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date