PATIENT AUTHORIZATION FOR FAMILY/FRIENDS

Patient name: ____________________________ Date of Birth: _________

I authorize ___________________________________ (_____) ______- ________
Name Phone Number

Relationship to Patient: ____

I authorize the above named person(s) to obtain the following information from my medical records or health provider:

Please initial any/all of the following items that you authorize to be released.

________ Recent patient visit

________ Care Instructions from my Health Provider

________ Any medical information requested from my medical records

________ Laboratory or test results

________ Prescription information

This authorization is valid from _______________________ and expires _____________

I understand that I have the right to revoke this authorization at any time by providing written notice to Dermatology Associates, P.C. I also understand that the revocation is not applicable to information already disclosed while the authorization was in effect.

Signature: ____ Date: _________________