



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: _____