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DERMATOLOGY

PROTECTED HEALTH INFORMATION RELEASE: PATIENTS 18 YEARS AND OLDER

Please check all applicable boxes and fill in any blank spaces where information is requested.

Patient Name ______________________________ DOB ______________

☐ Only release information to me personally (unless marked below)

☐ You have my authorization to speak with my Spouse/Significant Other about my medical care and test results.

Spouse/Significant Other's Name ______________________________ Phone__ ______________

☐ I authorize you to speak with my adult family members or other individuals about my medical care identified here:

Name ______________________________ Phone______________
Relationship ______________________________
Name ______________________________ Phone______________
Relationship ______________________________
Name ______________________________ Phone______________
Relationship ______________________________
Name ______________________________ Phone_ ______________
Relationship ______________________________

☐ You have my authorization to leave information on my answering machine regarding my medical care/test results.

☐ Other, please describe: ______________________________

Emergency Contact:

Last Name ______________ First Name ______________ Phone______________
Address______________ City______________ State________ Zip__________
Relationship to Patient______________________________

______________________________ ______________
Patient Signature Date

Have Patient/Guardian Date And Initial Annually:

Reviewed: ______/______ Date Initial	Reviewed: ______/______ Date Initial	Reviewed: ______/______ Date Initial
Reviewed: ______/______ Date Initial	Reviewed: ______/______ Date Initial	Reviewed: ______/______ Date Initial
Reviewed: ______/______ Date Initial	Reviewed: ______/______ Date Initial	Reviewed: ______/______ Date Initial