Comprehensive Dermatology Group
PEDIATRIC & ADULT SPECIALISTS

Patient Name: _____ DOB: _____

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Under HIPAA requirements, we are not allowed to give any of your health information to anyone else without your consent. Please sign below if you wish to have us leave or discuss information regarding your appointment, test results, or procedures with a member of your family. Signing this form will only allow us to discuss appointment information, test results, and procedure information with the persons listed below.

I authorize Comprehensive Dermatology Group to release appointment information, test results, and procedure information to the following individuals:

1. _____ Relation to patient: _____

2. _____ Relation to patient: _____

Patient Signature: _____ Date: _____

AUTHORIZATION TO LEAVE A MESSAGE ON ANSWERING MACHINE

Under HIPAA requirements, we are not allowed to give any of your health information to anyone else without your consent. Please sign below if you wish to have us leave information regarding your appointment, test results, or procedures on a voicemail or answering machine. Signing this form will only allow us to leave appointment information, test results, and procedures information on the phone numbers listed below.

I authorize Comprehensive Dermatology Group to leave a message regarding appointment information, test results, or procedure information on the following answering machines/ voicemails.

1. (_____)_____

2. (_____)_____

3. (_____)_____

Patient Signature: _____ Date: _____