ADA DERMATOLOGY- PROTECTED HEALTH INFORMATION RELEASE

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

- Only release information to me personally.

- You have my permission to speak to my spouse about my medical care.

  Name___________________________________
  Phone number___________________________

- You have my permission to leave information on my answering machine regarding my medical care and test results.

- You have my permission to talk with my children or other family members involved with my medical care.

  Name____________________________________
  Phone number ___________________________
  Relationship_____________________________

  Name____________________________________
  Phone number____________________________
  Relationship_____________________________

- Other, please describe____
  ____
  ____

Patient Signature____

Date__________________________________