

Authorization to release medical information

Release of Protected Health Information:

- ☒ Please leave voice or text message at home/cell number with results
☐ Do not leave messages with results, just leave a call back number
I give consent to communicate any results to authorized individuals below:

Authorized Individual(s)- relationship and phone #

Name : *

Consent for Appointment Reminders, Phone calls and Emails

☐ I hereby consent to and authorize Dermatology to send me notifications and appointment reminders via text messages, phone calls, and/or emails. I understand that messaging and data rates may apply according to my cellular plan. I understand that I am not obligated to receive, or continue to receive these communications, and may unsubscribe at any time by submitting a written request to the office.

Guardian Name : undefined
Guardian Relation : undefined