matherne
DERMATOLOGY + AESTHETICS

MEDICAL INFORMATION RELEASE FORM

Name: _____

Date of Birth: _____ Phone#: _____

Release of information

I authorize the release of information including the diagnosis, results, records, examination rendered to me, and claim information to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This **RELEASE OF INFORMATION** will remain in effect until terminated by me in writing.

_____ _____

Print and signature of patient (if over 18) Date

_____ _____

Print and signature of guarantor (if patient is under 18) Relationship to patient