DERMATOLOGY LTD

CHESLEY OFFICE CAMPUS • GEORGETOWN BUILDING, SUITE 100 • 101 CHESLEY DRIVE, MEDIA, PA 19063
TELEPHONE: (610) 566-7111 • FAX: (610) 891-6735

SPEAKMAN HOUSE • SUITE 100 • 1790 ROUTE 202 SOUTH • GLEN MILLS, PA 19342-8157
TELEPHONE: (610) 566-7111 • FAX: (610) 891-6735

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **Patient DOB:** _____

I authorize Dermatology LTD to release confidential medical information to:
(Parent, Spouse, Family Member, Personal Representative)

_____	_____	_____
Name of Individual	Relationship to the Patient	Phone Number

I DO_____ **I DO NOT**_____ consent to having medical information left on a voicemail or answering machine. (Please initial to the right of the appropriate response.)

I hereby certify that I understand the nature of the release of the above information.

X_____ Date: _____
Signature of Patient or Personal Representative

Personal Representative Information (if applicable):

_____	_____
Name of Personal Representative	Relationship to Patient (or other authority)