DERMATOLOGY LTD

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Patient DOB: _____

I authorize Dermatology LTD to release confidential medical information to:

_____ _____
Name of Individual and 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: _____
Patient Signature

_____
Witness