DERMATOLOGY
PROFESSIONALS, PA

Personal Release

Patient Name ___________________________ **Account #_______________**

****Personal Release**: If you would like to authorize Dermatology Professionals to be able to leave or discuss your appointment (dates/times), financial, and/or medical information with someone other than yourself in your home or person of your choice: (other than doctor).

_______ NO _______ YES

Personal Release 1

Name: ____

Relationship: ___________________________________

_____ Same phone # as Patient Different phone # (________) _________-_______________

Personal Release 2

Name: ____

Relationship: ___________________________________

_____ Same phone # as Patient Different phone # (________) _________-_______________

Patient Signature _______________________________________ **Date**______________