AUTHORIZATION TO RELEASE INFORMATION

I authorize Springville Dermatology to leave messages regarding my treatment; including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates by the following method (please circle **Yes** or **No**):

Yes / No Home/Voicemail: ______________ **Yes / No** Cell Phone/Voicemail: ________________

I authorize Springville Dermatology to release any information regarding my treatment; including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates. This includes leaving message(s) on the designated contact(s) phone number. Springville Dermatology may not release information to the named individuals and or entities unless you identify them below.

Name: ______________________________________ Relationship to Patient: ________________

Name: ______________________________________ Relationship to Patient: ________________

Name: ______________________________________ Relationship to Patient: ________________

Emergency Contact: ***(not at the same residence)*** Authorization to Release Information: **Yes / No**

Name: ______________________________________ Relationship to Patient: ________________

Phone Number: _______________________________

Springville Dermatology will use my home phone/cell phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, names(s) of medication(s), and information pertaining to my treatment and/or office updates. I will ensure this information is up to date at every visit.

Printed Patient Name: ____ Date of Birth: ___________

Signature of Patient/Insured/Guardian: __________________________________ Date: _________________

Printed Name of Party Above: ____

Witness-Office Staff: ____ Date: _________________