Dermatology
ASSOCIATES of Northern Kentucky

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Statement of Release

Print Patient's Full Name_____ Date of Birth_____

The purpose of this form is to give the providers and staff of this office permission to release your medical information (such as lab or test results) to any person you designate when we are unable to reach you. This will also allow us to give your medical information to a friend or family member who may call on your behalf. This consent will remain in effect until updated by you.

☐ I hereby authorize the providers and/or clinical staff of Dermatology Associates of Northern Kentucky to release information pertaining to my patient file to the following person(s):

_____ _____ _____
(Name) (Telephone) (Relationship)

_____ _____ _____
(Name) (Telephone) (Relationship)

☐ I DO NOT authorize the providers and/or clinical staff of Dermatology Associates of Northern Kentucky to release information pertaining to my patient file to any person(s).

My Preferred Phone Number: _____

Messages may be left on my answering machine / cell phone / voice mail:

☐ *YES* ☐ *NO*

Patient OR Guardian Signature:

_____ Date: _____

Staff Initials:_____