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 **DO** 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).

Emergency Contact (IF different from the person listed above)

Name: _____ Relationship to Patient: _____

Phone Number: _____

Patient OR Guardian Signature:

_____

Date: _____

Staff Initials: _____