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.

____ **YES** - 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)

____ **NO** - I don't 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(s) listed above)**

Name: _____ Phone Number:_____

If you prefer not to list an emergency contact, please check this box: ☐

***My** Preferred Contact Phone Number:*_____

Messages may be left on my voicemail OR answering machine: _____ YES _____ NO

I hereby consent to receive text message communications from Dermatology Associates of Northern Kentucky and their affiliated partners/associates concerning my healthcare. I acknowledge my right to withdraw this consent and opt out of text messaging services at any point.

SIGNATURE OF PATIENT (or Legal Guardian if patient is under 18)

_____ Date: _____

Staff Initials:_____