Dermatology & Skin Surgery
Center of York

PATIENT NAME: _____ DOB: _____

RELEASE OF INFORMATION

*** This Release of Information will remain in effect until terminated by me in writing ***

___ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

___ Spouse: _____

___ Child(ren): _____

_____

___ Other: _____

___ Information is NOT to be released to anyone other than me.

MESSAGES

Please call me: _____ at home _____ at work _____ on my cell

If unable to reach me:

_____ You may leave a detailed message on the recording

_____ Leave only a name and number and ask to return the call

I understand that I may change the information at any time by asking to complete a new Designated Individuals Release Form.

_____ DATE: _____

SIGNATURE OF PATIENT (IF OVER 18)/PATIENT'S PARENT OR LEGAL GUARDIAN SIGNATURE

If signed by a parent/legal guardian, print name of signature above: _____