BEND DERMATOLOGY
CLINIC
DERMASPA

RELEASE OF MEDICAL INFORMATION/ CONTACT PERMISSION

In the event that we need to contact you (patient) regarding medical information about an appointment, lab/biopsy result, medication, or any other reason, it is permissible to release your information:

Leave a message on an answering machine/voicemail? _____ YES _____ NO

Speak with spouse / significant other? _____ YES _____ NO

Name:_____ Phone number: _____ Relationship:_____

Speak with other family members? _____ YES _____ NO

Name(s): _____Phone number: _____ Relationship:_____

- OR -

I DO NOT authorize my medical information to be released to anyone _____ (Initial)

_____ _____ _____

Patient (or responsible party) Signature Patient PRINTED Name Date