



alaska
center
for
dermatology

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