CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY

I consent to disclosure of the following protected health information about me to the following family members or persons involved in my care:

- ☐ All my medical information
- ☐ Pathology and other laboratory test results
- ☐ Information necessary to schedule appointments for me here or with other providers
- ☐ Information necessary to help my family members take care of me
- ☐ Information necessary to provide, call in, or pick up prescriptions for me

☐ No
☐ Yes If yes, please provide their names and phone numbers:

Name:_____
Relationship:_____
Phone #:_____

Name:_____
Relationship:_____
Phone #:_____

May we leave your pathology results, laboratory test results, and other detailed medical information on your answering machine or cell phone voice mail?

☐ No
☐ Yes If yes, please provide your phone numbers:

Home:_____
Cell Phone:_____

My consent will remain in effect as long as I am a patient of Blue Ridge Dermatology, P.A, unless and until I notify the Practice in writing of any changes.

_____ _____
Signature of Patient or Personal Representative Date Signed

_____ _____
Printed Name of Signer Relationship to Patient
(if signed by Personal Representative)