

DERMATOLOGIST MEDICAL GROUP OF NORTH COUNTY, INC.

Patient Name: _____ **Account #** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Many patients allow family members, care givers, or other individuals to discuss aspects of their medical circumstances and condition (test results, procedures, medications, appointments, etc.) Under HIPAA regulations, we cannot give patient personal health information to individuals other than the patient without the patient's written consent. If you wish to have your medical information released to other individuals, please complete the section below. This authorization will allow DMG to release information only to those individuals listed below.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on prior consent.

I authorize Dermatologist Medical Group of North County, Inc. to release my medical circumstances and condition, including but not limited to, test results, procedures, medications and appointments, to the following individuals:

1. _____ Relationship to Patient _____

2. _____ Relationship to Patient _____

This authorization covers all medical information prior to and up to one year after the date this Authorization is signed.

PATIENT SIGNATURE _____ **DATE** _____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS

From time to time it is necessary for representatives of Dermatologist Medical Group of North County, Inc. to leave messages for patients. The purpose of the messages is to remind patients of an appointment, notify the patients of test or procedure results, or to ask a patient to call the office regarding an issue or concern. At no time will a representative discuss your medical circumstances or condition without your consent. **The purpose of this consent is to authorize us to leave messages with members of your household or on your answering machine at home or at work.**

Please indicate below the phone numbers where we may leave messages with those who answer the telephone or leave a message on the answering machine or voice mail.

You have the right to revoke or change this consent at any time, in writing, except where we have already made disclosures in reliance on your prior consent.

HOME # _____ **CELL#** _____ **WORK#** _____

PATIENT SIGNATURE _____ **DATE** _____