NW DERMATOLOGY
INSTITUTE

PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

PATIENT NAME: ____

DOB: _______/________/________

I, ________________________________, hereby authorize NW Dermatology Institute to release
(name of patient)
any and all medical information and test results that pertain to me, to the following individuals.

Name: _________________ Phone #: ________________ Relationship to patient: _______________

Name: _________________ Phone #: ________________ Relationship to patient: _______________

Name: _________________ Phone #: ________________ Relationship to patient: _______________

I authorize NW Dermatology Institute to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying NW Dermatology in writing of my intent to revoke authorization or change the name(s) of the individual to whom information is to be released.

____________________________________ ____________________
(Signature of Patient) (Date)

____________________________________ ____________________
(Signature of Legal Guardian/Personal Representative/Power of Attorney) (Date)

____________________________________ ____________________
(Description of Authority to Act for the Patient) (Date)

___________________ ___________________ ___________________
(Name of Witness) (Witness Signature) (Date)

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