DISCLOSURE AUTHORIZATION FOR INFORMATION REQUESTS

It is the policy of this practice not to leave messages regarding your confidential medical information on voicemail, nor to discuss or leave messages about your condition or treatment with any relative or household member, unless you have given us permission to do so.

IF YOU WOULD LIKE TO PROVIDE THIS PERMISSION, PLEASE COMPLETE THE FOLLOWING:

Patient Name: _____ Date of Birth: _____

Preferred phone contact: ☐Home ☐Work ☐Cell

I give my permission to Boca Raton Skin Institute and its staff to leave medical information on voicemail at the following number(s):

☐ Home: _____

☐ Work: _____

☐ Cell phone _____

I give my permission to Boca Raton Skin Institute and its staff to discuss medical information with the following individual(s):

☐ Spouse (name): _____

☐ Caregiver (name): _____

☐ Other (name and relationship):_____

_____ _____

Signature of Patient (or Legal Representative) Date

If signed by Legal Representative:

Printed name: _____ Basis of authority: _____