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PERMISSION TO RELEASE MEDICAL INFORMATION

Front Range Dermatology Associates has my permission to leave personal information in the following locations in the event that I cannot be reached directly:

Please Initial:

Yes	No	NA	
____	____	____	Home Answering Machine/Voicemail
____	____	____	Work Voicemail
____	____	____	Email: ______________________________
____	____	____	Okay to discuss information/results with:
			Name:______________________________
			Relationship: ________________________

Patient Name____ ____________
(Print) (DOB)

Patient Signature: ____ ____________
(Date)

Witness: ____ ____________
(Date)

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