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**	
___	___	**Cell Phone or Home Answering Machine**
___	___	**Work Answering Machine**
___	___	**Email:** _____

Do you give us permission to discuss information, Tests/ Results, and financial information with anyone? If so, include their name below:

Name: _____

Phone #: _____

Relationship: _____

Patient Name_____ _____
(Print) (D.O.B)

Patient Signature: _____ _____
(Date)

Witness: _____ _____
(Date)