CENTRAL MINNESOTA
DERMATOLOGY

Personal Release- <u>This is an optional release and can be declined by leaving this form blank.</u>

PLEASE READ *****HIPAA Privacy Rules mandate that we can only discuss information regarding your account or medical care with YOU, the patient, and your physician. If you would like us to be able to leave or discuss your account information (appointment, financial or medical) with anyone else, they must be added as a personal release on your account. This includes spouse, family, friends, and caregivers.**

I authorize Central Minnesota Dermatology to be able to leave or discuss my protected health information with the following person or persons.

Personal Release (1):

Name: _____

Relationship: _____ Phone: (_____) _____

Personal Release (2):

Name: _____

Relationship: _____ Phone: (_____) _____

****SIGNATURE: _____ DATE: _____****

I permit a copy of this authorization to be valid in place of the original.

This authorization will remain in place until revoked in writing.

<u>I understand that it is my responsibility to inform Central Minnesota Dermatology of any changes related to this release.</u>

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<u>TO CANCEL THIS AUTHORIZATION</u>

I hereby revoke the above authorization / authorizations. (To revoke this authorization removes all person or persons listed)

Signature: _____ Date: _____

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