Authorization to Family Members:

I hereby authorize Miller Family Dermatology to release any information from my medical record, which will contain Protected Health Information such as clinical notes, billing, insurance information, along laboratory results and biopsy results to the individual(s) identified below.
Please note that the law does not require the recipient of this information to keep it confidential.

I, _____ (print name) **Authorize Miller Family Dermatology to Disclose My Information to:**

1)

Name: _____

Relationship: _____

Phone Number: _____

2)

Name: _____

Relationship: _____

Phone Number: _____

3)

Name: _____

Relationship: _____

Phone Number: _____

_____ _____

Signature **Date**

Miller Family Dermatology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Miller Family Dermatology cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-408-2431. TTY:711