CAROLINA DERMATOLOGY
OF GREENVILLE

Patient Name: _____

Date of Birth: _____

Authorization To Release Medical Information

If you are 18 years of age or older we must have your permission to discuss your treatment, medical, or financial information, etc., with anyone other than yourself. If a person's name is not listed on the consent form, we cannot discuss your information with them.

Please sign in ONLY ONE of the areas below

I hereby give my consent for Carolina Dermatology, PA and staff to review or discuss my medical treatment, lab results, pathology reports, and/or financial information with the following person(s), other than myself. I understand that I must submit a written request to amend this list.

1. _____ Relationship: _____
(First & Last Name) (Date of Birth)

2. _____ Relationship: _____
(First & Last Name) (Date of Birth)

3. _____ Relationship: _____
(First & Last Name) (Date of Birth)

Signature: _____ Date: _____

OR

If there is no one that you wish your information to be released to, other than yourself, please sign below:

DO NOT RELEASE ANY INFORMATION ABOUT MY MEDICAL RECORDS OR FINANCIAL INFORMATION TO ANYONE OTHER THAN MYSELF.

Signature: _____ Date: _____