Randall Dermatology, PC

CONSENT FOR LIMITED RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Email: _____ Last 4 SSN: _____ DOB: _____

Please check one of the following:

___ Restricted: Randall Dermatology, PC cannot speak to anyone regarding my appointments, prescriptions, or biopsy results.

___ Limited: Randall Dermatology, PC may speak to the person(s) I have listed below in regards to my appointments, prescriptions, or biopsy results, and may leave any messages regarding my care.

Randall Dermatology, PC may release limited information as indicated above to the following person(s):

_____ _____
Name/Relationship Phone number

_____ _____
Name/Relationship Phone number

** _____ ** _____
Signature Date

Rev. 3/17/21