DERMATOLOGY
OF NEW MEXICO

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Policy on Release of Protected Health Information to Family Members or Friends

Patient name: _____

Patient Date of Birth: _____

It is the office policy of Dermatology of New Mexico, LLC not to release Protected Health Information to family members or friends, except for parent/legal guardian, or other persons authorized by the patient.

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers please name those individuals below. Your Protected Health Information including diagnosis/results or treatment may be given to these individuals in the event we cannot reach you or if you ask us to do so.

If you do not want any of your medical information provided to any other person please check the box below.

❑ NO, I do not authorize my Protected Health Information to be release to any other individual

By signing below, you authorize the following people to receive information regarding your Protected Health Information which may include diagnosis/results, treatment and appointment reminders.

_____ _____
Signature Date

LIST FAMILY MEMBERS OR FRIENDS

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to patient: _____

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to patient: _____