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AUTHORIZATION TO DISCUSS MEDICAL INFORMATION WITH DESIGNATED PARTIES

PATIENT'S NAME: _____ DATE OF BIRTH: _____

I VOLUNTARILY REQUEST AND AUTHORIZE DR. MARIA ABELLO-POBLETE AND THE STAFF OF POBLETE DERMATOLOGY, TO DISCUSS AND RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO THE FOLLOWING:

PLEASE DESIGNATE FAMILY AND FRIENDS WITH WHOM WE CAN SHARE YOUR MEDICAL INFORMATION WITH:

DESIGNATED PARTY: _____ RELATION TO PATIENT: _____

DESIGNATED PARTY: _____ RELATION TO PATIENT: _____

DESIGNATED PARTY: _____ RELATION TO PATIENT: _____

____ INITIAL: I understand that I can revoke this authorization at any time through a written request.

____ INITIAL: I understand that my treatment cannot be contingent upon my signing of this authorization.

PRINT PATIENT REPRESENTATIVE'S NAME

DATE

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

DATE