Goodman Dermatology, P.C.
Medical, Surgical, and Cosmetic Dermatology
Adult & Pediatric
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Date:_____

Patient Name:_____

D.O.B.:_____

Patient Number:_____

I,_____, authorize GOODMAN DERMATOLOGY P.C. and its staff to release any of my medical information to the following person(s).

_____relationship_____

_____relationship_____

_____relationship_____

Signature:_____

Date:_____

Witness:_____