

# SANFORD DERMATOLOGY

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## HIPAA Release of Information

Messages regarding office appointments may be left on my:

- Cell phone       Home phone       Work phone  
 Email       Sent as text to cell phone

Messages regarding information related to my care may be left on my:

- Cell phone       Home phone       Email

It is okay to discuss my health information with:

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Please let us know if someone else is allowed to bring your child to be seen here at Sanford Dermatology. This will authorize the following people to make all medical decisions on the parent(s) behalf. If someone that is not the parent or not listed on this form comes with your child they will not be able to be seen without written consent.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

This HIPPA Release of Information was signed by:

\_\_\_\_\_  
Printed Name – Patient or Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Relationship to Patient  
(if other than patient): \_\_\_\_\_