CENTER FOR DERMATOLOGY
ERIK B. HURST, MD

I acknowledge receipt of Center for Dermatology HIPAA Privacy Notice.

Signature: _____

Date: _____

Printed name of patient: _____

If you are signing as the patient's representative

Print your name: _____

Describe your authority: _____

I give permission for any medical information to be released to the following family member(s):

_____

_____

Do you have a Power of Attorney (POA) of a Surrogate Decision Maker (SDM)?

If yes, print name and phone number:

_____

I give permission for the following doctor(s) office(s) to have access to my medical records: