PETERSON DERMATOLOGY

Verbal Communication Release

Patient Name: _____ Medical Record# _____

Patient DOB: _____

I authorize the use or disclosure of the above-named individual's health information as described below. I understand that I have the right to refuse to sign this authorization.

I authorize PETERSON DERMATOLOGY, 1204 Joseph St. Dodgeville, WI 53533 to make the disclosure.

The following individual or organization is authorized to receive disclosure:

Individual/ Organization Name:

_____

Address

_____

_____

Phone number:

_____

Describe the type and amount of information to be used or disclosed as follows:

- ❑ Healthcare information
- ❑ Any information not authorized by this disclosure_____

Purpose of the disclosure_____

_____ _____

Signature of Patient Date