CONSENT FOR RELEASE OF
PROTECTED HEALTH INFORMATION TO FAMILY

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of my care: _____

_____

_____

This Release applies to all of the following:

All my medical information
Information necessary to schedule appointments for me
Lab or test results
Information necessary to provide, call in or pick up prescriptions for me
Information necessary to help my family member(s) take care of me
Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me
Information necessary to bill for or submit claims for care provided to me to government or private insurance payors

My consent will remain in effect as long as I am a patient of Eastern Dermatology & Pathology, PA unless and until I notify Eastern Dermatology & Pathology, PA in writing of any changes.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient