bliss dermatology
Michelle Pennie, MD

Release of Protected Health Information (PHI)

I authorize the release of all medical and claims information to the following:

Name: _____Phone: _____Relationship_____

Name: _____Phone: _____Relationship_____

Name: _____Phone: _____Relationship_____

Name: _____Phone: _____Relationship_____

[ ] No protected health information will be released to anyone except me.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

This *Message* permission will remain in effect until terminated by me in writing.

Patient Signature:_____

Date: _____