NORTHSHORE DERMATOLOGY CENTER, S.C.

Authorization to Disclose Protected Health Information

Authorization(s) for_____
(patient name)

Authorization #1:

Last Name: _____

First Name: _____

Relation to Patient: _____

Home Phone: _____ Mobile Phone: _____

Expiration Date(MM/DD/YYYY): _____

Authorization #2:

Last Name: _____

First Name: _____

Relation to Patient: _____

Home Phone: _____ Mobile Phone: _____

Expiration Date(MM/DD/YYYY): _____

Patient Signature: _____ Date: _____