



Sound Dermatology

FAMILY AND OTHER INDIVIDUALS INVOLVED IN YOUR CARE

I authorize Sound Dermatology to verbally disclose my medical, financial, and appointment information to the individuals listed below, unless otherwise specified. This may include, but is not limited to, information related to my medical condition, treatment, billing, insurance, and appointment scheduling.

I do NOT authorize Sound Dermatology to disclose my information to anyone.

Name of Individual	Relationship	Phone Number

Include Emergency Contact(s) listed on Intake Form

This authorization will remain in effect unless revoked in writing by the patient.

Signature of Patient/Personal Representative

Date

Printed name of patient or responsible party

Relationship to patient