CONSENT TO DISCLOSE INFORMATION TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

- Do you authorize Germain Dermatology to discuss your medical treatment with anyone other than yourself (including but not limited to prescriptions, lab results, etc.)? Please check one of the following:

  □**YES** □**NO**

If yes, please indicate representative below:

*****if name is not listed, we *CANNOT* disclose any of your information to anyone other than yourself*****

1. Family Member/Personal Representative: ______________________________
   Relationship to Patient: ______________________
   Phone Number: ____________________________

2. Family Member/Personal Representative: ______________________________
   Relationship to Patient: ______________________
   Phone Number: ____________________________

- What is the best number to reach you during working hours (8am-5pm)?

Home ______________________Work _____________________ Cell _____________________

Conditions for Disclosure: (please check the item(s) that apply)

□ The practice may disclose my personal health information to the individuals above only in my presence.
□ The practice may disclose my medical information to the individuals above in discussions in my presence and when I am not physically present, including disclosures by telephone, fax, email or regular mail.
□ Other Conditions of Disclosure: ________________________________

I, _________________________, understand I am designating the above mentioned person as my representative. I acknowledge that Germain Dermatology has my authorization to disclose my private health information to my designated representative for all purposes while lawfully observing all HIPPA privacy rules and regulations. I also understand that designating someone as my representative is an optional choice and I may choose not to do so at this time by leaving the above form blank. This consent may be revoked by me at any time by written notice to the practice and will expire in one year.

_____________________________________ ______________________

Signature of Patient **Date**