North Pointe Dermatology

Authorization Form to share PHI

I, _____ Authorize North Pointe Dermatology to communicate, share my medical history and care with the following members of the family.

1. Name_____
   Relationship_____ Phone#_____

2. Name_____
   Relationship_____ Phone#_____

3. Name_____
   Relationship_____ Phone#_____

This Authorization is valid for 1 year unless otherwise stated.

Patient/Guardian Name _____Relation_____

Signature_____Date_____

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