Health Contact Authorization

Patient Information:

Patient *Name (first, middle initial, last)*	*Date of Birth (MM/DD/YYYY)*	*Phone Number*

By signing this agreement, I authorize The Dermatology Center at Ladera to release my health information to the contacts listed below.

I can revoke this consent or update the listed contacts at any time for future disclosures by calling the office at (949) 364-8411 or by completing a new consent form.

Please list any contacts with whom we can discuss the patient's care/emergencies/finances in detail (e.g., spouse, parent, child, etc.):

Contact Name	*Relationship to Patient*	*Phone Number*
Contact Name	*Relationship to Patient*	*Phone Number*
Contact Name	*Relationship to Patient*	*Phone Number*

Agreement:

✘ _____ _____

Signature of ***Patient (or Parent/Guardian)*** *Date*

If you are signing as a Parent or Guardian, please print your name and provide your date of birth below:

_____ _____

Printed Name of ***Parent/Guardian*** *Date of Birth (MM/DD/YYYY)*