Highlands Dermatology
Paul S. Cabiran, MD
Jane Pressler, NP
Rachael Feibelman, NP

Release of Information Authorization Form

Acknowledgment of Receipt of Notice of Privacy Practices

This signed form acknowledges that you have received a copy of our practice's Notice of Privacy Practices as required by Federal Law. By signing below you are acknowledging that you understand and have read this notice. This notice is yours to keep.

_____ _____

Please Print Patient Name Patient Date of Birth

_____ _____

Signature of Patient/ Guarantor/ Legal Guardian Date

With whom may we discuss patient's information? (For patient over age 18)

[ ] Patient Only

1. Name: _____ Relationship: _____

What type of information may we share? [ ] Medical [ ] Financial

2. Name: _____Relationship: _____

What type of information may we share? [ ] Medical [ ] Financial

3. Name: _____ Relationship: _____

What type of information may we share? [ ] Medical [ ] Financial

This authorization is in effect until revoked in writing.