DERMATOLOGY PHYSICIANS GROUP

Minor/Dependent Patient Contact Consent for Protected Health Information

In order to provide the best quality of care, our doctors and medical staff will need to be able to reach you to discuss issues pertinent to your child/dependent's care: e.g., pathology results, laboratory test results, prescription refills.

Please list all family members or guardians that we are authorized to speak with regarding your child/dependent's medical care and information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Authorized telephone numbers:

Preferred #: _____ May we leave a message? ❑Yes ❑No

Alternate #: _____ May we leave a message? ❑Yes ❑No

Alternate #: _____ May we leave a message? ❑Yes ❑No

Name of minor/dependent patient: _____ Age: _____

Name of Parent/Guardian: _____ Relation: _____

Patient/Guardian Signature: _____ Date: _____