1673 Gezon Parkway SW Wyoming, MI 49519
Phone - 616-243-DERM (3376) Fax – 616-243-3377

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____Date of Birth_____

The person named above is or has been a patient of Wolverine Dermatology

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Do you authorize Wolverine Dermatology to leave a message with any of your (PHI) Protected Health Information on your voicemail? Yes No (circle one)

The person named above hereby authorizes Wolverine Dermatology to share their protected health information (PHI) to the following:

_____	_____	_____
Name	***Relationship to Patient***	***Phone***
_____	_____	_____
Name	***Relationship to Patient***	***Phone***
_____	_____	_____
Name	***Relationship to Patient***	***Phone***

Authorization:

_____	_____
Printed name of Patient	**Printed name of Authorized Representative (if not the patient)**

_____	_____	_____	_____
Signature of Patient or Authorized Representative	**Date**	**Signature of witness**	**Date**

If not signed by the patient, indicate relationship of authorizing person to patient:

☐ Parent or guardian of minor child
☐ Guardian or conservator of conserved patient
☐ Beneficiary or personal Representative of a deceased individual