K DERMATOLOGY
& AESTHETIC CENTER

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AUTHORIZATION TO DISCUSS MEDICAL INFORMATION WITH DESIGNATED PARTIES

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

I VOLUNTARILY REQUEST AND AUTHORIZE DR. SAIRAH KHOKHER AND THE STAFF OF K DERMATOLOGY & AESTHETIC CENTER, TO DISCUSS AND RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO THE FOLLOWING:

PLEASE DESINGATE FAMILY AND FRIENDS WITH WHOM WE CAN SHARE YOUR MEDICAL INFORMATION WITH:

DESIGNATED PARTY: _____ **RELATION TO PATIENT:** _____

DESIGNATED PARTY: _____ **RELATION TO PATIENT:** _____

DESIGNATED PARTY: _____ **RELATION TO PATIENT:** _____

_____ **INITIAL: I understand that I can revoke this authorization at any time through a written request.**

_____**INITIAL: I understand that my treatment cannot be contingent upon my signing of this authorization.**

_____ _____
PRINT PATIENT REPRESENTATIVE'S NAME **DATE**

_____ _____
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE **DATE**