CHICO DERMATOLOGY

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I, _____ hereby give my consent for the following person/people to pick up any prescriptions/sample medications, medical records/written information, or to speak with a nurse or provider on my behalf regarding my medical condition.

_____	_____	_____
Name of Individual	Relationship to Patient	Date
_____	_____	_____
Name of Individual	Relationship to Patient	Date
_____	_____	_____
Name of Individual	Relationship to Patient	Date

DURATION: This authorization shall become effective immediately and shall remain in effect until the patient withdraws their permission by signing the bottom of this form.

_____ _____
Patient's Signature Date

_____
Patient's Date of Birth

I am withdrawing my consent for the above person/people to act on my behalf.

_____ _____
Patient's Signature Date

_____
Patient's Date of Birth

RETAIN IN PATIENT CHART