RICHMOND DERMATOLOGY

9816 Mayland Drive • Richmond, VA 23233

Release of Information

May we leave personal medical information and/or test results on your voicemail? **Y / N**

Phone number: _____

Do you authorize our office personnel to discuss your medical information with anyone else?

❑ No, I do not authorize.

❑ Yes, I authorize the following individuals:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

In case of emergency, contact: _____

Relationship:_____ Phone Number:_____

Print Patient Name

Signature of Patient (or Parent/Guardian if minor) **Date**