CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

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AUTHORIZATION TO DISCUSS HEALTHCARE INFORMATION

I, _____, give permission to Contour Dermatology and Cosmetic Surgery Center to disclose and discuss my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

HEALTH INFORMATION TO BE DISCLOSED (Check all that apply):

- ☐ My complete health record (including but not limited to both medical and cosmetic: diagnoses, lab tests, prognosis, treatment, scheduling and billing, for all conditions)
  OR
- ☐ My complete health records, as above, with the expectation of the following information: (please specify):
  _____
  _____
  _____
  _____
  _____
  _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____
  unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying Contour Dermatology and Cosmetic Surgery Center, preferably in writing.)

_____
Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date