



**Consent and Authorization for Parents or Persons for Non-Minor Patients (over 18 years of age)**

Today's Date \_\_\_\_\_  
Patient's Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_

This is my authorization and consent for the below named person or persons to act on my behalf in regards to receiving information from or making requests to Alaska Family Dermatology, LLC. I acknowledge that granting authorization to the individuals listed below, to request services on my behalf, does not release me from financial responsibility.

***Please initial all that apply (signature at bottom of page is also required)***

- \_\_\_\_\_ Request/Receive Medical Records
- \_\_\_\_\_ Request prescriptions
- \_\_\_\_\_ Pick up prescriptions
- \_\_\_\_\_ Speak to a staff and receive medical advice on my behalf
- \_\_\_\_\_ \_\_\_\_\_

Person(s) authorized for the activities initialed above:  
Name and relationship to Patient:

\_\_\_\_\_  
\_\_\_\_\_

This authorization will remain in effect for one year unless so designated in writing that such consent is canceled.

\_\_\_\_\_  
Print your Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature Date