Consent and Authorization for Parents of 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 Relationship to Patient:
_____ _____

_____ _____

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

_____
Print your Name

_____
Signature

_____
Signature Date