FAIRFIELD DERMATOLOGY

IF YOU WOULD LIKE SPOUSES, PARENTS, CHILDREN, FAMILY MEMBERS, OR CAREGIVERS TO HAVE ACCESS TO YOUR MEDICAL RECORDS:

I agree that the following people may have access to my complete medical record. I may rescind this in writing at any time.

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Declined

PARENT OR RESPONSIBLE PARTY (only for minors)

Name: _____ Social Security: _____

Address (if different from patient): _____

Date of Birth: _____/_____/_____ Relationship to Patient:_____

PCP: _____ **Referring Physician**:_____

Patient Name: _____ DOB: _____

Signature: _____ Date:_____