**Release of Medical Information (ROI) to Another Family Member or Individual**

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**PATIENT NAME** **DATE OF BIRTH** **PHONE NUMBER**

If you wish to have Meridian Dermatology, PLLC release your medical or billing information to another individual or family member you must sign this form. Signing this form will only give information to individuals indicated below. To request records from another medical clinic, please fill out a separate Release of Protected Health Information (PHI) form.

1. NAME: ______________________________

   PHONE: ______________________________

   RELATION TO PATIENT: ________________

2. NAME: ______________________________

   PHONE: ______________________________

   RELATION TO PATIENT: ________________

3. NAME: ______________________________

   PHONE: ______________________________

   RELATION TO PATIENT: ________________

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

______________________________________________________________________

**SIGNATURE** of Patient or Personal Representative* **DATE**

*Personal Representative includes: parent of any minor patient under 18 years of age, legal guardian, power of attorney etc.