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**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Patient Number: \_\_\_\_\_

I, \_\_\_\_\_, authorize Metropolitan Dermatologic Surgery, P.C. and its staff to release any of my medical information to the following person (s).

\_\_\_\_\_ relationship \_\_\_\_\_

\_\_\_\_\_ relationship \_\_\_\_\_

\_\_\_\_\_ relationship \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_