RELEASE OF INFORMATION

I, ________________________, give Barrington Park Dermatological Associates, P.C. my
(Patients name)
permission to release biopsy results, blood work results and any Medical or Billing information to the following person(s) on my behalf:

Name:	Relationship:	Contact Number:
____________________	____________________	____________________
____________________	____________________	
____________________	____________________	

Patient signature ____________________________________ Date___________

If patient is under the age of 18:

Parent/Guardian Signature_____________________________ Date___________

PRIMARY CARE DOCTOR

DR.____________________________________