DATE: _____ ID#: _____

MUSICK DERMATOLOGY | SKINCEUTICALS ADVANCED CLINICAL SPA

PATIENT NAME: _____

EMAIL: _____

PHONE NUMBER: _____

Can we leave messages with number provided above regarding appointment/test results?

YES / NO

PATIENT INFORMATION RELEASE

I authorize the person(s) listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case.

I have the right to terminate this agreement at any time by informing the staff in writing.

AUTHORIZED PERSON(S)	RELATIONSHIP TO PATIENT	PHONE NUMBER

PATIENT SIGNATURE: _____