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RELEASE OF INFORMATION

I, _____, give Barrington Park Dermatological Associates, P.C. my
(Patient's 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 Name _____ DOB _____ Date _____

If patient is under the age of 18:

Parent/Guardian Name _____ Date _____

PRIMARY CARE DOCTOR

DR. _____