Cosmetic Dermatology and Vein Center
Dr. Scott Friedman DO
Consent to share personal health information

I give permission for the following people to have unlimited access to my medical records, appointment information and billing information at Dr. Friedman's office.

I also understand that at any given time I may remove any names from this list. This agreement is valid for a period of one year from the date of signature.

Name	Relationship	Phone

I also give the staff at Dr. Friedman's office permission to leave a detailed voice message/text that may include test results on my: (Circle one or more and include number)

CELL HOME NONE

In the event of an emergency please contact:

Name:_____ Number:_____

Patient Name (Printed): _____

Signature:_____ Date:_____