



340 State Route 34 S, Suite 203  
Colts Neck, NJ 07722  
732-677-2049  
[info@kdermnj.com](mailto:info@kdermnj.com)  
[www.kdermnj.com](http://www.kdermnj.com)

**AUTHORIZATION TO DISCUSS MEDICAL INFORMATION WITH DESIGNATED PARTIES**

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I VOLUNTARILY REQUEST AND AUTHORIZE DR. SAIRAH KHOKHER AND THE STAFF OF K DERMATOLOGY & AESTHETIC CENTER, TO DISCUSS AND RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO THE FOLLOWING:

*PLEASE DESIGNATE FAMILY AND FRIENDS WITH WHOM WE CAN SHARE YOUR MEDICAL INFORMATION WITH:*

DESIGNATED PARTY: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_

DESIGNATED PARTY: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_

DESIGNATED PARTY: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_

- INITIAL:** I understand that I can revoke this authorization at any time through a written request.
- INITIAL:** I understand that my treatment cannot be contingent upon my signing of this authorization.

\_\_\_\_\_  
PRINT PATIENT REPRESENTATIVE'S NAME DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE