I, _____, hereby authorize OnSpot Dermatology to release and discuss my protected health information with the following individual(s):

Authorized Individual(s):

- **Name of Authorized Person: _____**
- **Relationship to Patient (e.g., Spouse, Sibling, Caregiver): _____**
- **Phone Number: _____**
- **Email Address: _____**

I understand that the authorized individual(s) will be allowed to access, review, and discuss my medical records, treatment plans, medications, lab results, and any other health-related information related to my care.

This authorization also allows the designated individual(s) to request information and communicate with OnSpot Dermatology on my behalf.

Patient's Signature: _____

Date: _____