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**VERBAL AUTHORIZATION**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I \_\_\_\_\_ hereby authorize Gulf Coast Dermatology, and/or any of it's employees to discuss anything related to my medical treatment and/or billing with the following :

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
**Patient Signature** **Date**

\_\_\_\_\_  
**Witness Signature** **Date**