Ozark Dermatology Clinic

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TO REQUEST RELEASE OF MEDICAL INFORMATION FROM OZARK DERMATOLOGY CLINIC, PLEASE COMPLETE AND SIGN BELOW.

I, _____, hereby voluntarily authorize the disclosure of information from my health record.

Patient Name: _____ Medical Record Number: _____

Patient's Date of Birth: _____ Patient's SSN: _____

Please send:

OFFICE NOTES/LAB RESULTS/PATHOLOGY RESULTS

Purpose of Release: **Continuation of Care**

Please send the above medical records from Ozark Dermatology Clinic to the following healthcare provider:

Name of Organization or Provider: _____

Address:

_____

City/State/Zip:

_____

Phone Number: _____ Fax Number: _____

_____ _____

Patient's Signature of Patient's Representative **Date**

_____ _____

Printed Name of Patient or Patient's Representative **Relationship to Patient**