Fayetteville: 479.443.5100
Bentonville: 479.273.7006
Siloam Springs: 479.373.6566
Lowell: 479.347.2700

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 Represe ntative Relationship to Patient