OZARK DERMATOLOGY

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

TO REQUEST RELEASE OF MEDICAL INFORMATION FROM ANOTHER HEALTHCARE PROVIDER, 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 all the above medical records to:
Ozark Dermatology Clinic
4375 N. Vantage Drive, Suite 305
Fayetteville, AR 72703
Phone: 479.443.5100 Fax: 479.443-5117

_____ _____
Patient's Signature of Patient's Representative Date

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