# AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

To: _____

_____

_____

Patient Information:

Name: _____

Address: _____

_____

_____

Date of Birth: _____

I request that my medical records and health information (or, in the alternative, furnish a copy of my medical records and health information) be provided/transferred and disclosed to:

Tamara L. Hill, M.D.
Hill Dermatology, PLLC
309 SE Frank Phillips Blvd
Bartlesville, OK 74003

I am authorizing the following information to be furnished and disclosed:

☐ All of my medical records and information

☐ Medical records and information for the following dates of service: _____

_____

☐ Other: _____

A photocopy of this authorization will be accorded the same force and effect as the original.

I understand that my medical information may include records that may indicate that I have or have been treated for a communicable or non-communicable disease. I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed name of Patient or Patient's Representative

Representative's authority:

☐ Parent of a minor

☐ Legal Guardian

☐ Power of Attorney

☐ Other: _____

This authorization is only effective if it is signed and dated. This authorization expires on: _____ (or if this is left blank, one year after the date it is signed)