AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

To: Regional Dermatology, P.C.
501 SE Frank Phillips Blvd, Suite 202
Bartlesville, OK 74003

Patient Information:
Name: _____
Address: _____
_____
_____

Date of Birth: _____

I request that Regional Dermatology and Dr. Eslicker provide/transfer my medical records (or, in the alternative, furnish a copy of my medical records) and disclose health information 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 maintained by Regional Dermatology
☐ 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)