OHIO SKIN CENTER

DERMATOLOGY • SURGERY • COSMETICS

RELEASE OF PATIENT MEDICAL RECORDS

_____

Name of Healthcare Provider

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

_____

Street Address

_____

City, State and Zip Code

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose my full and complete protected medical information to ***The Ohio Skin Center.***

This disclosure should include:

_____: Office notes; inpatient, outpatient, and emergency room treatments; clinical charts; reports; treatment plans; hospital admission records; discharge summaries and test results.

_____: Laboratory records and specimens; radiology records and films.

_____: Prescription records and drug information related to such records.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

_____ _____

Patient Signature Date

999 Brubaker Drive, Suite 3, Dayton, Ohio 45429

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