Southwestern Dermatology

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Authorization for the Release of Medical Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Date of Birth: _____

I hereby authorize Southwestern Dermatology to release photocopies of my medical records into my own keeping or to the following individual or organization:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

The facility, its employees and officers and the attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized by this release. I understand this consent can be revoked at any time except for any disclosure already made in good faith, in reliance on this release. I realize by the receipt or authorized release of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

I acknowledge that the law of the state of Oklahoma provides the following:

> **The information authorized for release may include records which may indicate the presence of a communicable, non-communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

_____ _____
Signature of Patient Date of Signature

_____ _____
Signature of Person Authorized to sign if other than patient Relationship to Patient