MIDTOWN DERMATOLOGY
2424 East 21st Street, Suite 340
Tulsa, OK 74114
(918) 728-3100 Fax: (918) 728-3376

Medical Records Release Form

Date: _____

Please print the following information for the doctor you are requesting your records FROM:

Name of Doctor: _____

Address of Doctor: _____

Phone # of Doctor: _____

I, _____, authorize the release of all my medical records and medical information (which may include records/information sent by another physician) to:

Midtown Dermatology
2424 East 21st Street, Suite 340
Tulsa, OK 74114

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON-COMMUNICABLE DISEASE.

Please print the following information:

Patient's Name: _____

Date of Birth: _____

Records Requested: _____

Signature: _____ Date: _____

Relationship to Patient: _____
(If someone other than the patient is signing)