Dermatology ASSOCIATES of Northern Kentucky

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Adult & Pediatric Dermatology • Dermatologic Surgery • Mohs Micrographic Surgery
Laser & Cosmetic Surgery • Dermatopathology

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Dermatology Associates of Northern Kentucky, P.S.C. (James A. Zalla, M.D., Mark J. Zalla, M.D., Susan J. Bushelman, M.D., Molly J. Eisner, M.D, Mae L. Dinn, MPAS, PA-C, Kristin D. Kennedy, APRN, and Marie N. Sartori, APRN) to release medical information including diagnosis, medical care, treatment, laboratory results, and all tests performed regarding my treatment in their office.

Records To Be Released To: _____

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_____

Patient Name _____

D.O.B. _____

_____ _____

Witness Signature Signature of Patient

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Date

Rev. 01/20