

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Dermatology Associates of Northern Kentucky, P.S.C. (Mark J. Zalla, M.D., Susan J. Bushelman, M.D., Molly J. Eisner, M.D, Clayton D. Conner, 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:

Patient Name

D.O.B.

Witness Signature

Signature of Patient

Date