Dermatology ASSOCIATES of Northern Kentucky

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Laser & Cosmetic Surgery • Dermatopathology

AUTHORIZATION FOR RELEASE

OF MEDICAL INFORMATION

I hereby authorize _____

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To release medical information including diagnosis, medical care, treatment, laboratory results, pathology reports and/or slides, and all tests performed, or specifically as follows:
_____regarding:

Name _____ D.O.B._____
To:

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_____
Signature of Patient

_____
Witness Signature

_____
Date

Rev. 06/22