EVI
DERMATOLOGY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of my (or my minor child's) confidential medical records as indicated below. I understand that this information may include sensitive health information. I also understand that I may revoke this authorization at any time by submitting a written request to EVI Dermatology.

FROM/TO	FROM/TO
EVI Dermatology	_____
1512 SW 119th ST	_____
Oklahoma City, OK	_____
Ph: 405-310-6000	_____
Fax: 405-280-1398	_____

Information to be Released:

- o Entire Medical Record
- o Pathology Reports
- o Laboratory Reports
- o Other: _____

Patient Name		DOB	
Legal Guardian		Relationship	
Signature		Date	