

**PATIENT AUTHORIZATION FOR TREATMENT  
AND RELEASE OF INFORMATION**

**AUTHORIZATION FOR TREATMENT:** By virtue of my signature below, I authorize Dermatology Associates of Tulsa, LLC (DAT) and any of its employees or other authorized personnel or agents, to provide general healthcare service to me.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** I hereby authorize DAT and any of its employees or other authorized personnel or agents, to release any of my medical records or other personal or medical information for purposes of determining benefits for services; for purposes of obtaining reimbursement from my insurance company of record, any public agency or any other potential third party payer. I also agree to allow DAT and any of its employees or other authorized personnel or agents to leave answering machine /voice mail messages and other forms of contact, including mail to my home or other designated location. I further authorize DAT and any of its employees or other authorized personnel or agents, including any laboratory of diagnostic testing facility performing services on my behalf, to release any of my medical records or other personal or medical information to any employee, authorized personnel or other agent of any physician, laboratory or diagnostic testing facility, or other healthcare provider involved in my care or treatment, for purposes of billing or obtaining reimbursement from any payer, or for the purpose of developing an appropriate treatment plan or diagnosis.

I further authorize DAT to use any photographic images, which may be part of my medical records, for training purposes as indicated. I understand that such images will be adjusted as needed to eliminate identifying features (i.e., cropping so no full face images are identified, if applicable).

According to Section 1052.2 of Title 63 of the Oklahoma Statutes, medical information cannot be supplied to insurance companies or to State or Federal agencies without the following statement:

I authorize DAT to release any medical information pertaining to my medical care and treatment to my insurance companies necessary for the processing of my insurance claim. **SUCH RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THAT I HAVE OR MAY HAVE A COMMUNICABLE OR VENERAL DISEASE, INCLUDING BUT NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS (ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME OR AIDS).**

**DATE** \_\_\_\_\_ **SIGNATURE** \_\_\_\_\_

I acknowledge that I have viewed a copy of and /or been provided access to the **Notice of Privacy Practice** for DAT.

**DATE** \_\_\_\_\_ **SIGNATURE** \_\_\_\_\_

**FOR MEDICARE PATIENTS ONLY**

I request authorized **MEDIGAP** benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above **MEDIGAP** carrier any information needed to determine these benefits or the benefits payable for related services.

**DATE** \_\_\_\_\_ **SIGNATURE** \_\_\_\_\_