THE Dermatology GROUP

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I, _____, give permission to The Dermatology Group, Inc. and/or their representative to release any medical information to the following:

Name: _____

Relationship to patient: _____

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Phone No. _____ Fax No. _____

Patient Name: _____

Date of birth: _____

Patient/Guardian signature: _____

Date of signature: _____ Phone: _____

Samir B. Patel, MD - Founder
Samantha Barry, MD
Mohammad Diab, MD
Elizabeth Uhlenhake, MD
Danielle Waymire, MD

Nathan Weir, MD
Kristine Zitelli, MD
Bria Barjuca, CNP
Ashley Carrasquillo, CNP
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Abigail Main, PA-C
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any medical information from:

Name: _____

Address: _____

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to the following:

The Dermatology Group, Inc.

5298 Socialville-Foster Rd.

Mason, Ohio 45040

(513) 770-4212 Fax: (513) 770-4213

Patient Name _____Date of Birth _____

Patient Signature_____

Date of Signature_____

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