Date: ______________________________

To:

____

____

This is your authority to release medical information of the patient listed below to:

JACKS DERMATOLOGY

1710 West 42nd Avenue

Pine Bluff, Arkansas 71603

Jennifer L. Jacks, M.D.

(870)-534-7546 Office

(870)-534-2343 Fax

Patient Name: ________________________________

Date of Birth: ________________________________

Address: ____________________________________

Phone: ______________________________________

Patient/Guardian Signature: ____________________

Relationship to Patient: _______________________