

Michael J. Crowe, MD

Board-Certified:
American Board of
Dermatology

Artis P. Truett III, MD

Board-Certified:
American Board of
Dermatology

Tina Snodgrass,
MSN, ARNP-C

Dana N. Jennings, PA-C

Angela L. Mills, PA-C

Sandra B. Cox, ARNP-C

For healthy skin

- Dermatologic surgery, including skin cancer removal
- Mohs micrographic surgery
- Laser surgery for hemangiomas and port-wine stains
- Treatment of warts and precancerous keratosis
- Treatment of psoriasis and vitiligo
- Rashes and eczema (dermatitis) therapy
- Acne treatment
- Mole evaluation and removal

For beautiful skin

- Gentle laser skin treatments for wrinkles, scars, age spots, sun freckles and blemishes
- Photofacial™ treatment
- Medically advanced chemical peels
- Laser hair removal and waxing
- Birthmark removal
- Blood vessel removal
- Botax® therapy
- Cellulite reduction
- Advanced skin care products
- Makeup consultations
- Facials

Affiliated Location:



Atkinson Medical Building
1413 N. Elm St. • Suite 202
Henderson, KY 42420
Tel: (270) 830-7546
Fax: (270) 830-7575
www.HendersonDerm.com



Authorization To Release Information

This will authorize: Owensboro Dermatology Associates
2821 New Hartford Rd
Owensboro, KY 42303

To release my protected health information to:

Name of Person/Facility receiving information

Address of Person/Facility receiving information

Extent or nature of information to be disclosed:

- Complete Medical Record
- Biopsy Report (s)
- Lab Report (s)
- Consultation Report
- Medication (s)
- Allergy Test/Treatment
- Surgical Procedures
- Other _____

Patient Name: _____

Patient's Date of Birth _____

I understand that my records are protected under State and Federal Confidentiality Regulations (HIPPA) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, except to the extent that actions have already been taken.

*Note: ODA has up to 30 days to fulfill medical record release authorization.

Patient's Name Printed: _____

Patient/Guardian Signature: _____ Date _____

Provider Signature: _____ Date _____

This form must be completed in its entirety before any information will be released

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