AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name:____

Date of birth:______________________________ Phone:_____________________________

Address:____

I authorize the release of medical health records from:

Facility:____

Address:____

Phone:____________________ Fax:___________________

I authorize the release of my medical records, including diagnosis and treatment to:

Desert Sky Dermatology
1688 E Boston Street, #101
Gilbert, AZ 85295-6220
Phone (480) 855-0085
Fax (480) 855-0086

Include records for the period from:_______________________to:______________________.

[ ] All records [ ] doctor/visit notes [ ] Path reports [ ] Lab reports

Please mail records that exceed 20 pages. Thank you!

This authorization releases Desert Sky Dermatology and any staff, employees and agents of any responsibility for information contained in such records release in case of loss or theft from my person, or distress of any type caused to me or others. Desert Sky Dermatology will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release.

I hereby authorize the release of my medical records indicated above, including all HIV and communicable disease related information, and do herewith release Desert Sky Dermatology of any/all liability in relation to said release of information.

_______________________________ _____________________________
Patient signature, parent or guardian Today's date

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Relationship to patient