AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name:_____

Date of birth:_____ Phone:_____

Address:_____

I authorize the release of medical health records from:

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

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

Facility:_____

Address:_____

Phone:_____ Fax:_____

Include records for the period from:_____to:_____.

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

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. Please allow 10 business days for record release.

_____ _____

Patient signature, parent or guardian Today's date