

# Authorization for Release of Medical Information

MRN: \_\_\_\_\_

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, PLLC**

1688 E Boston St. STE. #101 Gilbert, AZ 85295

7205 E Baseline Rd. Mesa, AZ 85209

Phone: 480-855-0085

Fax: 480-855-0086

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 as 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 legal guardian

\_\_\_\_\_  
Date

Relationship to patient if applicable: \_\_\_\_\_