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**:

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

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

☐ I will pick-up my records in the office.

☐ Email : ____________________________

By selecting email I acknowledge that my email may not be a secure form of communication and could potentially be viewed by others.
I authorize Desert Sky Dermatology to email my records to me that the provided email address above.

☐ Mail

By selecting mail I acknowledge my address listed above is accurate. I authorize Desert Sky Dermatology to mail my records to me provided above.
I understand that if my record is over five pages there will be a $12 processing and postage fee.

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: ______________________