dermatology SOLUTIONS

Authorization for Release of Medical Records

This release authorizes:

Facility: _____

Address: _____

Phone: _____

Fax: _____

To disclose my medical health information, including diagnosis and treatment to:

Dermatology Solutions
4915 E Baseline Rd Ste #124
Gilbert, AZ 85234
Phone: 480 832-2213
Fax: 480 832-2077

Include all records for the period of _____ to _____

☐ All Records

☐ Doctor/Visit Notes

☐ Path Reports

☐ Lab Reports

Release health information by:

☐ Fax

☐ Mail

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

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

Patient Name: _____ *Date of Birth:* _____

Address: _____ *Phone:* _____

Patient Signature: _____ Date: _____