

MEDICAL RECORDS RELEASE

Patient Name: _____ Date of birth: _____

I have been informed of Arizona Skin Institute's Privacy Practices and I **authorize** the doctor or facility listed below to provide a complete copy of my confidential medical records.

Name: _____

Address: _____

In addition to the general authorization to release records to the persons or entities listed above, I authorize the release of the records described as the following:

- | | | |
|--|------------------------------|-----------------------------|
| Communicable disease-related information, including records of testing, diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Drug and alcohol treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pathology, lab work, photographs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Progress notes, history & physicals | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

This request covers dates of service: 2 years prior from last date seen Other dates: _____

The purpose of this disclosure is: Change of insurance/physician Continuation of care Referral

Other: _____

This authorization is valid for six (6) months from the date of signing and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal law.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature of Patient or Legally Authorized Representative

Signature of Witness

Printed Name of Patient or Legally Authorized Representative

Printed Name of Witness

Description of Legal Authority

Date