Authorization to Request Information

I hereby authorize Center for Dermatology & Plastic Surgery to request my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV') and Acquired Immune Deficiency Syndrome ("AIDS'), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization.

I understand that my records may be subject to disclosure by the recipient, and may no longer be protected by federal privacy regulations.

_____

Print Patient Name Date of Birth

I authorize you to release the following specified protected health information to:

Center for Dermatology & Plastic Surgery Phone: 480-905-8485
14275 N 87th Street, Suite 110 Fax: 480-905-7274
Scottsdale, AZ 85260

From the health records of:
Name of physician/facility/entity:_____

_____

Street Address

_____

City, State, Zip Phone Number Fax Number

Check all protected health information that may be released: **Dates may range:**

- All Medical Records
- Patient Notes
- Visit Notes
- Path Reports
- Lab Reports
- Procedure Reports
- Medical History
- Other___

From: __

To: ____

Purpose of disclosure:

- Medical Care
- Insurance

❑ Attorney ❑ At the request of the patient
❑ Other_

I understand that this authorization will expire by law 180 days from the date of this authorization.

_____ _____

Signature of Patient or Patient's Representative Date

_____ or _____

Printed Name of Patient's Representative Legal Authority (attach supporting documents)

_____ _____

Relationship to Patient Center for Dermatology & Plastic Surgery Representative