****AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION****

Patient's Full Name: _____

Phone #: _____ Date of Birth: _____

Address: _____

I hereby authorize the release, use or disclosure of my medical records from:

Name of Clinic: _____

Address: _____

Phone #: _____ Fax #: _____

For the Following Date(s) of Service: From: _____ To: _____

☐ Complete Records ☐ Treatment Records ☐ Pathology Reports
☐ Medication Record ☐ Lab Reports ☐ Progress Notes
☐ Other (please specify) : _____

I authorize the following persons (or class of persons) to receive my Protected Health Information:

Summit View Dermatology
8405 E Baseline Rd. Suite #104
Mesa, AZ, 85209
Phone #: 480-674-3295 Fax #: 725-239-7974
Info@summitviewdermatology.com

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above.

_____ _____

Patient Signature, parent or guardian Date

Relationship to patient if applicable: _____

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