Experts in Skin Disease Treatment & Prevention™

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MEDICAL RECORDS RELEASE

I, ______________________________, (DOB:________________)
am requesting that a copy of my medical records, as indicated below, be sent to:

Doctor: ____

Phone: ____________________ Fax: ____________________

Please send a copy of the following types of medical records:

- ❑ Complete Medical Record
- ❑ Biopsy Report(s)
- ❑ Pathology Slide(s)
- ❑ Lab Report(s)
- ❑ Consultation Reports
- ❑ Medication Allergies
- ❑ Allergy Test/Treatment
- ❑ Surgical Procedures
- ❑ Complete Medical Records including outside providers
- ❑ Other ________________________

____
Patient Signature Date

____
Witness Signature Date

This authorization for medical records release expires 90 days from date signed.

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20401 N. 73rd St, Ste 230, Scottsdale, AZ 85255 | 13995 W. Statler Blvd, Ste 150, Surprise, AZ 85374 | 41810 N. Venture Dr, Ste D-136, Anthem, AZ 85086 | 19646 N. 27th Ave, Ste 305, Phoenix, AZ 85027 | 1459 S. Higley Rd, Ste 106, Gilbert, AZ 85296 | 16515 S. 40th St, Ste 135, Phoenix, AZ 85048