Precision Dermatology
13640 N. 99th Ave. #300, Sun City, AZ 85351
(623) 875-2600 Phone/(623) 875-2621 Fax

AUTHORIZATION TO OBTAIN RECORDS

I, _____ (Patient name-**please print**) authorize Precision Dermatology to obtain all my medical records which may include information concerning communicable diseases such as HIV, AIDS, mental illness (except psychotherapy notes), chemical/alcohol dependency and Diagnosis and treatment information from:

Doctor: _____
(First name) (Last name)

Address: _____

Phone/Fax: _____

This authorization is for release of records of my care and treatment for the last _____ years inclusive.

Disclosure of the information is requested for the purpose of: _____
_____

Patient DOB: _____

Patient/Guardian Signature: _____ Date: _____

Witness's Signature: _____ Date: _____

EXPIRATION DATE OF THIS AUTHORIZATION: _____

For the protection of the patient, this is not a valid release if not witnessed and if not entirely complete. This authorization is valid for 6 months unless revoked in writing. It cannot be revoked retroactively for information already released.

NOTICE TO THE PATIENT: Please make arrangements with your previous physician(s) office to obtain any records for personal use. In addition, prior to providing our office with any records you may already have, please retain a copy for yourself. **If any portion of this authorization is returned incomplete, there will be a delay in the processing of this request until completion.**