ARIZONA ADVANCED DERMATOLOGY

DISEASES OF THE SKIN CUTANEOUS LASER SURGERY COSMETIC DERMATOLOGIC SURGERY

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MEDICAL RECORD RELEASE

Date ____________________

Patient Name: ____________________________

Date of Birth: ____________________________

I hereby authorize Arizona Advanced Dermatology to release my medical records to:

Name or Organization ____

Address ____

Phone Number _____________________ Fax Number _______________________

Including *all* information regarding the diagnosis and treatment or examination rendered to me during the period from _______________to ____________________________

Or Only the specific dates of service, or diagnosis, listed below:
____

_____________________________ _____________________________
Name Of Patient (PRINT) Date of Birth

____
Signature of Patient or Guardian

____
Relationship to Patient, if applicable

____
Witness