

ARIZONA ADVANCED DERMATOLOGY

DISEASES OF THE SKIN

CUTANEOUS LASER SURGERY

COSMETIC DERMATOLOGIC SURGERY

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3509 S. Mercy Rd Suite 103 Gilbert, AZ 85297 Fax (480) 855-7739

(602) 264-9044

MEDICAL RECORD REQUEST

Date _____

Patient Name: _____

Date of Birth: _____

I hereby authorize _____ to release my medical records to:

Arizona Advanced Dermatology

___ 740 E. Highland Ave. Suite 101 Phoenix, AZ 85014 Fax (602) 264-0057

___ 8817 E. Bell Rd. Suite 101 Scottsdale, AZ 85260 Fax (480) 513-2322

___ 3509 S. Mercy Rd Suite 103 Gilbert, AZ 85297 Fax (480) 855-7739

Telephone 602-264-9044

Please indicate which office you would like your medical records be sent to.

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