**Arizona Premier Dermatology**
4545 East Chandler Boulevard, Suite 305 | Chandler, Arizona 85048
Phone: (480) 785-7546 | Fax: (480) 940-1760
Email: Info@AZPremierDerm.com | Website: AZPremierDerm.com

# AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

PATIENT NAME (Last, First, Initial): _____

MAIDEN/OTHER NAME: _____ DATE OF BIRTH: _____

I hereby authorize the transfer of the following healthcare information:

- ☐ Entire contents of chart: _____
- ☐ Progress notes: _____
- ☐ Pathology reports: _____
- ☐ Lab reports: _____
- ☐ Other: _____

To:

_____

_____

_____

_____

From:

Arizona Premier Dermatology
4545 E Chandler Blvd., Suite 305
Phoenix, AZ 85048

**I understand that specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I also understand this Authorization is subject to revocation/withdrawal by me at any time in writing to the custodian of medical records in your office, except to the extent the action has already been taken to release this information to Arizona Premier Dermatology. This Authorization shall remain valid unless revoked but will expire in one year after signing. I have a right to inspect a copy of the health information to be released, and if I do not sign this Authorization, your office will not release my health information to Arizona Premier Dermatology. Notice is given to Arizona Premier Dermatology that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV, and mental health treatment.**

By signing below, I agree that all of the above information is correct.

_____ _____

**Patient Signature** **Date** **Signature of Parent / Guardian** **Date**

_____ _____

**Witness Signature** **Date** **Relationship to Patient**

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