PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Today's Date:_______________________________

Patient Name:____

Date of Birth:_________________________ Phone Number: _________________________

This is: ☐ A One-time Disclosure ☐ A Continuing Disclosure for 12 months from signed date

I hereby authorize Ironwood Dermatology, PC to release my medical records to:

Name/Organization:____

Address:____

Phone Number:_______________________ Fax Number:____________________________

Please select ***one*** option below:

☐ Include all information regarding the examination, diagnosis and treatment rendered to me during the period from _________________________ to____________________________

☐ Include only the specific dates of service or diagnosis listed below:

____

Please allow 10 business days for your request to be completed.

I hereby authorize the "Release of Medical Information / Protected Health Information". I, the patient or patient's representative, have the legal right to inspect, copy and request delivery as specified of this Protected Health Information within the next 30 days in accordance with Public Law 104-191 (HIPPA-1996). I accept the responsibility of any fees that may be associated with this request. I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation.

Patient Signature:_______________________________________ Date:_________________

Patient's Legal Representative's Signature:_____________________Printed Name:__________________

1735 E. Skyline Dr. Tucson, AZ 85718 ● 10211 N. Oracle Rd. Oro Valley, AZ 85737
Tel: (520) 618-1630 ● Fax: (520) 618-1636

Office Use Only
Form Accepted by ________________ Date ______________ Completed by ________________ Date ______________