IRONWOOD
DERMATOLOGY
& AESTHETIC SERVICES

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 the following entity to release my medical records to Ironwood Dermatology, PC
10211 N Oracle Rd., Oro Valley, AZ 85737 ● Fax: (520) 618-1636:

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 date 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:_____

Patients 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 _____