EAST VALLEY DERMATOLOGY CENTER
&
VALLEY SKIN CANCER SURGERY

1100 S Dobson Road, Suite 223
Chandler, Az 85286
Phone: 480-821-8888 Fax: 480-821-0888

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This release authorizes:

Healthcare Provider: ____

Address: ____

City: ________________________ State: ______ Zip: _______

Phone: ______________________ Fax: _____________________

To release the information specified below from the medical records maintained when I was treated at the above facility.

_______ Doctor's Notes

_______ Lab Reports

_______ Path Reports

_______ Hospital Notes/Consults

_______ Other (Please Specify): ____________________________

Send or Fax the requested medical records to:

East Valley Dermatology Center / Valley Skin Cancer Surgery
1100 S Dobson Road, Suite 223
Chandler, Az 85286
Fax: 480-821-0888

I understand that I may revoke this consent at any time and that, upon fulfillment of the above stated purpose, this consent will automatically expire in one (1) year following the date of the signature without my express revocation.

Patient Printed Name: ________________________________ DOB: _______________

Patient/Guardian Signature: ____________________________ Date: _______________