EAST VALLEY DERMATOLOGY CENTER

Adult and Pediatric Dermatology

RELEASE OF INFORMATION AUTHORIZATION

I _____ authorize East Valley Dermatology Center to release any/all information regarding my diagnosis and treatment to the following person(s) below, until I notify you otherwise.

ADD:

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____
4. _____ Relationship to Patient: _____
5. _____ Relationship to Patient: _____

I _____ request that East Valley Dermatology Center *REMOVE* the following people from any previously authorized lists, until I notify you otherwise:

REMOVE:

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____

PATIENT PRINTED NAME: _____ DOB: _____

PATIENT SIGNATURE: _____ DATE: _____

1100 South Dobson Road, Suite 223 • Chandler, AZ 85286
Phone (480) 821-8888 • Fax (480) 821-0888 • www.evderm.com