



ALPINE DERMATOLOGY

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENTS FULL NAME:

ADDRESS:

DATE OF BIRTH:

THIS AUTHORIZES: Alpine Dermatology

TO RELEASE INFORMATION SPECIFIED TO: _____

This authorization releases Alpine Dermatology and any of its staff, employees, and agents of any responsibility for information contained in such records released in case of loss or theft from my person' or distress of any type caused to me or others.
Alpine Dermatology will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release.

PHOTOCOPIES OF INFORMATION TO BE RELEASED:

_____ Medical records of the last two years of treatment

_____ including laboratory results

_____ other (specify) _____

I AUTHORIZE RELEASE OF RECORDS PERTAINING TO:

_____ Confidential HIV-related information (as defined in A.R.S. section 36-661)

_____ Confidential communicable disease related information (as defined in A.R.S. section 36-661)

_____ Confidential alcohol or drug abuse related information (as defined in 42-CFR section 2.1 ET SEQ)

_____ Confidential mental health diagnosis/treatment information

_____ Confidential genetic testing information (as defined in A.R.S. section 12-2801)

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE:

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

Signature of patient /guardian

Date signed

Signature of witness
guardian

Relationship to patient if signed by

REASON PATIENT WAS UNABLE TO SIGN

THERE IS NO CHARGE FOR RECORDS RELEASED TO A PHYSICIAN FOR CONTINUING CARE. A COPY/ ADMINISTRATIVE FEE IS CHARGED WHEN RECORDS ARE RELEASED TO A PATIENT OR OTHER NON-PHYSICIAN RECIPIENT.

Records are released upon written authorization of the patient