PIMA DERMATOLOGY, PC
5150 E. Glenn Street | Tucson, AZ 85712
520.795.7729 | www.pimaderm.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS & INFORMATION

Patient Full Name: _____ DOB: _____ / _____ / _____
(Month) (Day) (Year)

*If under age 18, full name of Parent or Guardian:*_____

Please fill out the side that applies:

To Release Medical Records & Information TO Pima Dermatology:	**To Release Medical Records & Information FROM Pima Dermatology:**
I hereby authorize: _____ *(Office and/or Provider)* Address:_____ City: _____ State: _____ Zip Code: _____ Phone: ( ) ____ - _____ Fax: ( ) ____ - ____ **to send/release photocopies of my medical records concerning the above named patient to:** Office**:** Pima Dermatology, PC Physician: **Sarah Schram, MD, Matthew Beal, MD & Associates** Address: 5150 E. Glenn Street Tucson, Arizona 85712 Phone: 520.795.7729 Fax: 520.795.4177 **Check all that apply:** ☐ All healthcare information relevant to skin condition or consult requests ☐ Healthcare information relating to the following treatment, condition or dates: _____ ☐ Other: _____	**I hereby authorize:** Physician: **Sarah Schram, MD, Matthew Beal, MD & Associates** Address: Pima Dermatology 5150 E. Glenn Street Tucson, Arizona 85712 Phone: (520) 795-7729 Fax: (520) 795-4177 **to release my healthcare information & photocopies of medical records concerning the above named patient to:** Physician/Practice Name: _____ Address: _____ City, State _____ , _____ Zip: _____ Phone: ( ) _____ - _____ Fax: ( ) ____ - _____ **Check all that apply:** ☐ All healthcare information relevant to skin condition or consult requests ☐ Healthcare information relating to the following treatment, condition or dates: _____ ☐ Other: _____

This authorization is valid for (180) days after the signed date below. I may revoke this authorization at anytime, providing written notification is provided. Once this office discloses healthcare information, the person or organization that receives it may re-disclose it, as privacy laws may no longer apply. Our practice will not condition treatments, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization.

Print Patient or Parent/Guardian Name: _____

Patient or Parent/Guardian Signature: _____ Date: _____