



Dr. Neil P. Superfon, D.O. Dr. William T. Ko, M.D. Dr. John A. Ebner, D.O. Dr. Edward Galicynski, D.O.

MEDICAL RECORD RELEASE

Date: _____

Patient Name: _____

Date of Birth: _____

I hereby authorize Arizona Dermatology to release my medical records to:

Name of Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

Include all information regarding the examination, diagnosis and treatment rendered to me during the period from _____ to _____

Or only the specific dates of service, or diagnosis listed below:



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 any fees that may be associated with this request.

Patient Signature: _____ Date: _____

Patients Legal Representative's Signature: _____

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2224 W. Northern Avenue
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Phoenix, AZ 85021
Tel: (602) 277-1449
Fax: (602) 263-8523

Paradise Valley Office
4835 E. Cactus Road
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Scottsdale, AZ 85254
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Gilbert Office
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Suite 202
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1500 S. White Mountain Road
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