arizona dermatology
and cosmetic surgery

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:_____

Phoenix Office
2224 W. Northern Avenue
Suite D-300
Phoenix, AZ 85021
Tel: (602) 277-1449
Fax: (602) 263-8523

Paradise Valley Office
4835 E. Cactus Road
Suite 155
Scottsdale, AZ 85254
Tel: (602) 996-3050
Fax: (602) 494-0481

Gilbert Office
4001 E. Baseline Road
Suite 202
Gilbert, AZ 85234
Tel: (480) 844-0510
Fax: (480) 844-1663

Show Low Office
1500 S. White Mountain Road
Suite 401
Show Low, AZ 85901
Tel: (928) 537-2550
Fax: (928) 537-1266