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 REQUEST

Date: _____

Patient Name: _____

Date of Birth: _____

I hereby authorize _____ _____ to release my medical records to:

Arizona Dermatology

___ 2224 West Northern Avenue, Suite D-300 Phoenix, AZ 85021	Fax (602)263-8523
___ 4835 East Cactus Road, Suite 155 Scottsdale, AZ 85254	Fax (602)494-0481
___ 4001 East Baseline Road, Suite 202 Gilbert, AZ 85234	Fax (480)844-1663
___ 1500 South White Mountain Road, Suite 401 Show Low, AZ 85901	Fax (928)537-1266

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:

_____

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
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Tel: (928) 537-2550
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