
PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Name: _____ D.O.B.: _____ Phone#: _____

I hereby authorize Desert Dermatology PLLC to request the following information contained in my medical records for the period from:

START DATE_____ to _____(END DATE).

- ☐ All PHI – Full medical Record
- ☐ All PHI except confidential (HIV, Alcohol & Drug therapy)
- ☐ Labs/ Pathology report
- ☐ Select Clinic Notes

Release Records **From:**

Office/ Doctors name: _____

Phone number: _____

Fax number: _____

**Please send to Desert Dermatology PLLC**

1521 E. Tangerine Rd. Suite 161

Oro Valley AZ 85755

Phone: 520-771-0288 Fax: 520-771-0289

This is: o A One-time Disclosure o A Continuing Disclosure

Signature _____

Relationship to Patient (if applicable) _____