Associated Dermatologists, P.C.

6296 E Grant Road, #180

Tucson, AZ 85712

Ph. (520)290-8555 FAX (520)290-6470

DIRECT MAIL ADDRESSES:

Joseph A. Hud, Jr. MD jhud@adermpc.emadirect.md

Scott D. Bangert, MD sbangert@adermpc.emadirect.md

Linda C. Barrows, MD lbarrows@adermpc.emadirect.md

Carolyn A. Bangert, MD cbangert@adermpc.emadirect.md

Tracey Newlove, MD tnewlove@adermpc.emadirect.md

Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Address: _____Phone: _____

I hereby authorize: _____

To send/release photocopies of medical records concerning the above patient to:

Name/Practice: Associated Dermatologists, P.C.

Address: 6296 E. Grant Road, #180, Tucson, AZ 85712

For the purpose of: _____ **Medical**

Records (Check One):

[ ] Pathology Reports [ ] Lab Reports [ ] Last Visit Note [ ] CCD (Sent via Direct Mail)

[ ] Only "Minimal Necessary" records information per HIPAA

[ ] The following described records only (specify type/date(s)

_____

This authorization is valid for 60 days after the signed date below. I may revoke this authorization at any time providing written notification is provided. I agree that a photocopy of this authorization is as valid as the original. I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Exclude the following information from the records released (please initial):

[ ] Drug/Alcohol abuse/treatment [ ] Sexually Transmitted Disease

[ ]HIV/AIDS diagnosis treatment/testing [ ] Mental Illness or psychiatric Diagnosis/Treatment

Signature: _____ Date: _____

Patient, Guardian, or Authorized Representative