Medical Records Release Form

Patient Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Provider/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

By signing this form, I authorize Desert Valley Dermatology to obtain my confidential health information regarding me by releasing a copy of my **medical record**, or summary of my protected health information, to the physician/facility listed above.

- ☐ **Complete Medical**
- ☐ **Records Pathology Report**
- ☐ **Lab Reports**
- ☐ **Surgical Reports**
- ☐ **Other**

_____ _____

Patient Signature Date

This authorization for medical records release expires 120 days from the date of signature.

Please email this form to **info@dvdderm.com**

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