130 S. 63rd Street ~ Suite 114 ~ Mesa, Arizona 85206

Phone: 480-981-2888 ~ Fax: 480-654-0599

Protected Health Information Request/Release Form

Today's Date: ____/____/_____

Use this form to request or to disclose copies of your protected health information that Alta Dermatology maintains regarding you.

Patient Name: ____ **Date of Birth:** ____/_____/_____ **Phone #:** (_____)________________________
(print)
Address: ____ **Fax #:** (_____)_____________________

E-mail:____ **Method of Retrieval:** ____________________

Reason For Request:
❑**Personal** ❑**Transfer of Care** ❑**Disability** ❑**Insurance** ❑**Legal Review** ❑**Continuing Care** ❑**Other**

Treatment Dates (or range)**:** _________________________________

❑**Physician Notes** ❑**Lab Results** ❑**Biopsy Reports** ❑**Complete Record** ❑**Other**________________________

Information to be released FROM:	**Information to be released TO:**
Organization/Person Name	Organization/Person Name
Street Address City, State, Zip	Street Address City, State, Zip
Phone Fax	Phone Fax

Patient signature: ____Date: ____/____/________

Parent or Legal Guardian:____Date: ___/_____/________

Print your name: _______________________________________Relationship to patient, if other than self:_____________________________

Minors age 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse. I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules. I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits). However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

This authorization will expire *"ONE year"* from the date the Authorization is signed.

For Alta Dermatology Group use only:
Documentation and proof of identity (type) _________________________________
Identity of individual or personal representative verified: [ ] Yes [ ] No

Signature of Alta Dermatology Personnel:___________________________________Date:_____/_____/_____ upd:12/28/17

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