

SKIN *and* CANCER CENTER *of* Arizona

An Established Tradition of Medical Excellence

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby give permission to allow the release/discussion of my medical information to _____, Relationship to Patient _____, should I not be available.

- I do not want the release of medical information given to anyone but myself.

- I agree to allow Skin & Cancer Center of Arizona to leave detailed messages/results on my voicemail at the following phone number(s):
 - Home _____
 - Cell _____
 - Work _____

- I do not wish for Skin & Cancer Center of Arizona to leave detailed messages/results on my voicemail.

I understand that it is my responsibility to inform Skin & Cancer Center of Arizona if there are any changes to the above information.

Patient

Date