SKIN and CANCER CENTER of Arizona

MEDICAL RECORDS REQUEST FORM
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_____ Date of Birth____/____/____
Address _____City_____State____Zip Code _____
Phone Number_____S.S.N._____

I hereby authorize the request of any and all medical records specified below. I understand that my records may contain information regarding diagnosis and/or treatment of HIV/AIDS related information, sexually transmitted diseases, drug and alcohol use/abuse, mental illness, developmental disabilities, genetic information and psychiatric treatment.

FROM:

Name of physician or organization_____
Address_____City_____ State___Zip Code_____
Telephone number_____ Fax Number_____

TO:

Skin & Cancer Center of Arizona
725 S Dobson Rd, Suite 200
Phone: 480 899-7546
Fax: 480 899-7599

__Burrell H. Wolk, M.D.
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__Edward Prodanovic, M.D.
__Kristian Balle, D.O.
__Beth Lopez, MPAS, PA-C
__Hilary Reznick, PA-C
__Kristina Todd, PA-C
__Laurie Quattro, PA-C

For the Specific Purpose of: _____Continuity and Coordination of Care _____Insurance/Payment Concern _____Medical Care
_____Educational Planning ____Personal _____Legal Investigation or Action _____Other (Specify): _____

Information to be Disclosed:__All Records (Specific justification: _____)
Pathology/Laboratory Reports (date of service_____) _____Progress Notes ___Other_____

Expiration Date of Authorization: This authorization is effective for one year from the date signed, unless otherwise specified by the patient.

Right to Terminate or Revoke Authorization: You may terminate or revoke this authorization, except to the extent that SCCA has already disclosed your medical information in reliance of this authorization by submitting a written revocation to the Skin & Cancer Center of Arizona's medical records department.

Right to Inspect and Copy my Medical Information: You have a right to inspect and copy your medical information in SCCA's records by submitting in writing to SCCA's medical records department. You understand that there may be a reasonable cost-based fee if permitted by and in accordance with applicable law to fulfill your request. You also understand that SCCA may deny your request to inspect and copy in certain very limited circumstances and if denied access, you may request the denial be reviewed.

Potential for Re-disclosure: Information that is disclosed under this authorization may be re-disclosed to the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

Not Required to Sign: You may refuse to sign this authorization without affecting your ability to obtain treatment at SCCA.

Right to Receive Copy of Authorization: You have a right to receive a copy of this authorization if you have agreed to sign it.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. A copy of this authorization will be considered as valid as the original.

Signature_____ _____
Patient or Guardian/Representative Signature Date

If signed by a Legal Representative, complete the following:
1. The Individual is: ☐a minor ☐Legally incompetent or incapacitated ☐activated POA for Health care
2. Legal authority: ☐patient* ☐legal guardian ☐next of kin/executor of deceased ☐activated POA for Health care

*By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order .