SOUTHWEST SKIN SPECIALISTS LTD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

*****Please fill in the information below all the way to where it states "For Office Use Only".*****

Patient Name _____

Patient Address _____

_____

Patient Phone _____

Date of Birth _____

Signature _____
Patient or Legal Guardian

Date _____

I hereby authorize Southwest Skin Specialists, Ltd., to provide a copy of the specific medical records requested by:

_____

The information will be used or disclosed for the following purpose:

_____

_____ Doctor's notes
_____ Lab/biopsy reports
_____ Other_____

----------FOR OFFICE USE ONLY----------

HJL _____ **JMG** _____ **MPC** _____
ACR _____ **BWL** _____ **SIH** _____
JKS _____ **NBP** _____ **KAY** _____

(Please circle as appropriate and physician will initial and date after review)

PLEASE FAX OR MAIL THIS FORM IN THE ATTACHED ENVELOPE

Fax Number: Phoenix 602-494-7103 Scottsdale 480-614-2429