Tucson Dermatology

Release of Medical Records Request Form

Patient Information:

Please provide the following details to ensure accurate processing of your request.
Patient Name: _____
Date of Birth: _____
Phone Number: _____
Email Address: _____

Records To Be Released:

I hereby authorize Tucson Dermatology to:

☐ Send my medical records to:
Name of Provider/Facility/Individual: _____
Address: _____
Phone Number: _____ Fax: _____

☐ Receive my medical records from:
Name of Provider/Facility/Individual: _____
Address: _____
Phone Number: _____ Fax: _____

Specific Information to Be Released (Please Check All That Apply):

☐ Complete Medical Record
☐ Office Visit Notes
☐ Pathology/Laboratory Reports
☐ Imaging Reports
☐ Billing Records
☐ Other (please specify): _____

Purpose of the Request:

☐ Personal

☐ Transfer of Care

☐ Insurance

☐ Legal

☐ Other (please specify): _____

Acknowledgement and Authorization:

I understand that:

1. This authorization is valid for one year from the date of my signature, unless otherwise specified.
2. I may revoke this authorization at any time by providing a written notice to Tucson Dermatology, except to the extent that action has already been taken based on this authorization.
3. I am aware that medical records may contain sensitive information, including but not limited to details about mental health, HIV/AIDS, drug/alcohol abuse, or other conditions.
4. I have the right to request a copy of this form after signing.

Patient/Authorized Representative Signature: _____

Date: _____

For Office Use Only:

Date Request Received: _____

Date Records Sent/Received: _____

Processed By: _____

Contact Information:

Tucson Dermatology
6565 E Carondelet Dr Suite 145
Tucson, AZ 85710
Phone: (XXX) XXX-XXXX | Fax: (XXX) XXX-XXXX
Email: [Insert Contact Email]