Sam P. Smith, D.O.

4915 East Baseline Road, Suite 102
Gilbert, AZ 85234
Phone: 480-646-8660 Fax: 480-646-8085

AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION

Patient's Name._____ Date of Birth:_____

_____ _____

Patient's Address City State Zip Code

I authorize: To release to:

Smith Dermatology
Mailing Address

4915 E. Baseline Ste 102 Gilbert, AZ 85234
480-646-8660 480-646-8605
Phone Number Fax Number

_____
Mailing Address

_____

_____ _____
Phone Number Fax Number

Please: MAIL / FAX / E-MAIL / I WILL PICK UP, E-MAIL THEM
TO:_____
CIRCLE ONE

My medical records are going to be used for:

_____ Continuing Care _____ Insurance Claim / Application _____ Legal _____ Other

Please send: _____ All medical records of the past two (2) years of treatment

_____ Specific records of these dates of service: _____

I authorize the release of photocopies of the specified medical records, including those which may contain information regarding alcohol, drug abuse, or psychiatric communicable disease unless otherwise here in writing:

_____.

I understand that there is NO CHARGE when records are mailed directly to a medical provider for continuing care. There is a charge of when records are mailed to any party other than a medical provider, including when given to me. I do understand and agree that the first set of records copied for my personal use is free or charge. Additional copies thereafter will cost an administrative fee of $50.

PLEASE ALLOW 7-10 DAYS FOR COMPLETION

_____ _____
LEGALLY AUTHORIZED REPRESENTATIVE (PRINT) DATE

X_____ _____
LEGALLY AUTHORIZED REPRESENTATIVE (SIGNATURE) RELATIONSHIP TO PATIENT