AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient's Name: _____ **Date of Birth:** _____

Address: _____ **Home Phone:** _____

_____

_____ **Alternate Number:** _____

Requesting Records From: Allure Dermatology- Brent D. Sloten, D.O. PLLC

Fax Number: 480-981-1625 **Phone Number:** 480-981-1214

Address: 1818 East Baseline Road Mesa, Arizona 85204

Fax or Mail To: _____

_____

_____

☐ **Release All Records**

☐ **Release only Medical Records Specified Below:**

_____

Reason for requesting records: _____

****

I authorize the release of the above requested records, including those, which may contain confidential HIV/AIDS related information, communicable disease related information, confidential information related to mental health, drug and/or alcohol use, or sexual history, and that the records be forwarded to the above name and address.
I further authorize that these medical records may be faxed if necessary.

I understand that I may revoke this authorization at any time, except to the extent that action based upon this authorization has already been taken. I have given my consent freely, voluntarily, and without coercion.

_____ _____ _____

Patient Signature (parent/legal guardian if minor) **Relationship to Patient** **Date**

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Fax or Mail To: Brent D. Sloten, D.O. PLLC

Fax Number: (480) 981-1625
Phone Number: (480) 981-1214
Office Address:
Allure Dermatology
1818 East Baseline Road
Mesa, Arizona 85204

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