ARIZONA MOHS SURGERY & DERMATOLOGY

Authorization for Use or Release of Medical Records

Arizona Mohs Surgery & Dermatology, PLLC
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By signing this authorization, I authorize Anir Dhir, MD, and/or Arizona Mohs Surgery & Dermatology, PLLC, to use or disclose my protected health information (PHI) as described below:

- ❑ I am requesting records to be sent **TO** AMS
- ❑ I am requesting records to be sent **FROM** AMS

Person or organization sending / receiving the information:

Name: _____
Address: _____
Phone: _____ Fax: _____
E-mail: _____

- ❑ Dates of Service from: ____/____/_____ to ____/____/_____

- ❑ Skin Biopsy Reports & Photos
- ❑ Surgical Reports & Photos
- ❑ Medication List
- ❑ Other: _____

I understand that this authorization is voluntary. If I do not sign this form, my healthcare from Arizona Mohs Surgery & Dermatology and the payment for my healthcare will not be affected. I understand that once my information is released, it may no longer be protected by Federal privacy regulations. Please be aware that if we are asked to e-mail your records, e-mail is not a direct transfer of information and we cannot guarantee the privacy and security of the information.

I understand that I may revoke this authorization at any time by notifying AMS's Privacy Officer in writing. However, such notification will not have any effect on actions that AMS took before the revocation was received.

_____ _____
Signature of Patient or Legal Guardian Printed Patient Name or Legal Guardian

Date Requested: ____/____/_____ Date of Birth: ____/____/_____