SKIN and CANCER CENTER of Arizona

MEDICAL RECORDS REQUEST FORM
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO SCCA

Patient Name_____ Date of Birth___/_____/_____
Address _____City_____State___Zip Code _____
Phone Number_____

I hereby authorize the use and disclosure of my medical records specified below. I understand that my records may contain information regarding diagnosis and/or treatment of sensitive conditions such as HIV/AIDS, sexually transmitted diseases, drug and alcohol use/abuse, mental illness, developmental disabilities, and genetic information, unless excluded here _____.

FROM:
Name of individual or organization_____
Address_____
City_____ State_____ Zip Code_____
Telephone number_____ Fax Number_____

TO:

Skin & Cancer Center of Arizona
725 South Dobson Road #200
Chandler, Arizona 85224
Phone: 480 899-7546
Fax: 480 899-7599

☐ Burrell H. Wolk, M.D.
☐ Gosia Nowak, M.D.
☐ Joseph P. Janik, M.D.
☐ Neil F. Fernandes, M.D.
☐ Henna Pearl, M.D.

☐ Beth Lopez, MPAS, PA-C
☐ Hilary Reznick, PA-C
☐ Vanessa Michael, PA-C

For the Specific Purpose of: _____Continuity and Coordination of Care _____Insurance/Payment Concern _Personal _____Legal Investigation or Action _____Other (Specify): _____

Information to be Disclosed: _____All Records (specific justification: _____)
___ Pathology/Laboratory Reports _____Surgical Reports _____Progress Notes ___Other_____

For the following dates: _____

Expiration Date of Authorization: This authorization is effective for one year from the date signed, unless otherwise specified by the patient.

Right to Terminate or Revoke Authorization: You may terminate or revoke this authorization, except to the extent that the disclosing individual or organization has already disclosed your medical information in reliance of this authorization, by submitting a written revocation to the individual or organization that you have authorized to disclose your information, above.

Potential for Re-disclosure: Information that is used or disclosed under this authorization may be re-disclosed to the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations. However, please note that SCCA is required to protect your information in accordance with federal and state law.

Not Required to Sign: You may refuse to sign this authorization without affecting your ability to obtain treatment, payment, enrollment, or eligibility for benefits at the disclosing individual or organization.

Right to Receive Copy of Authorization: You will receive a copy of this authorization if you have agreed to sign it.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. A copy of this authorization will be considered as valid as the original.

Signature_____ _____
Patient or Guardian/Representative Signature Date

If signed by a Legal Representative, complete the following:
1. Name: _____
2. The Individual is: ☐a minor ☐legally incompetent or incapacitated ☐deceased
3. Legal authority: ☐parent* ☐legal guardian ☐activated POA for Health care ☐next of kin/executor of deceased

*By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order.