STOCKTON
DERMATOLOGY

MEDICAL RECORD REQUEST

_____ _____
Patient PRINTED Name Patient's ID / SS#

_____
Patient's Date of Birth

I hereby authorize:

_____
Address: _____
City: _____State: _____Zip: _____
Phone Number _____Fax Number: _____

To release to: **STOCKTON DERMATOLOGY**
16611 S. 40th St # 100
Phoenix, AZ 85048
Phone (480) 610-6366
Fax (480) 833-1653

Toni C. Stockton, M. D.
Maggie A. Stark, PA-C
Alison Schriefer, PA-C
Laura Devlin, NP-C

Information to be released:
_____ All Records
_____ Office Visit Notes
_____ Laboratory/Path Reports
_____ Other:

I understand that I may revoke this authorization, in writing at any time, EXCEPT, after action has been taken in reliance on it, and in that event this authorization expires automatically. With respect to any mental health information that may be contained in the patient's medical records, I hereby waive my/his/her right to the privileges of confidentiality

_____ _____ _____
Signature of Patient/Parent/Authorized Legal Representative Date

_____ _____
Relationship to Patient Initials of Witness

This fax contains confidential information and is considered personal, confidential and privileged information intended recipient only. If you have received this fax in error please destroy it and notify us immediately to let us know it was in error. Thank you.