STOCKTON
DERMATOLOGY

MEDICAL RECORD RELEASE

____ _________________
Patient PRINTED Name Patient's ID / SS#

____
Patient's Date of Birth

I hereby authorize:

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

To release to (name of) Physician/Clinic/Patient:
____
Address: ____
City: _______________________________State: __________Zip: ________________
Phone Number ________________________Fax Number: _________________________

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.