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Authorization for Release of Medical Records

By signing this authorization, I authorize Michael J. Huether, M.D., P.C. and/or Arizona Skin Cancer Surgery Center, P.C., to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization permits Michael J. Huether, M.D., P.C. and/or Arizona Skin Cancer Surgery Center, P.C., to use or disclose to the following individually identifiable health information:

☐ All dates of service

☐ Dates of service:

_____/_____/_____ to _____/_____/_____

☐ Pathology Reports (skin biopsy)

☐ Surgical/Operative Procedures

☐ Other: _____

Please forward medical records to the following:

Doctor / Facility / Patient: _____
Street Address: _____
City, State, Zip: _____
Phone: _____
Fax: (*if less than 15 pages*) _____
E-Mail: _____

******Please be advised that medical records may take up to 2 weeks to be processed and sent*****

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Michael J. Huether, M.D., P.C. and/or Arizona Skin Cancer Surgery Center, P.C., have acted in reliance upon this authorization. My written revocation must be submitted to Privacy Officer c/o Michael J. Huether, M.D., P.C., at 5980 N. La Cholla Blvd., Tucson, AZ 85741-3535. Please be aware that if we are asked to e-mail your records, e-mail is not a direct transfer of information, we cannot guarantee the privacy/security of the information.

_____ _____
Signature of Patient or Legal Guardian **Print Patient Name or Legal Guardian**

Relationship to Patient: _____ **Date of Birth:** _____ / _____ / _____

FOR OFFICE USE ONLY:

Date Requested: _____ / _____ / _____ - _____
Date Reviewed: _____ / _____ / _____ - _____
Date Sent: _____ / _____ / _____ - _____

Sent By: mail | fax | picked up | email | - _____