



Authorization for Use or Release of Medical Records

Arizona Mohs Surgery, PLLC
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By signing this authorization, I authorize Anir Dhir, MD, and/or Arizona Mohs Surgery, PLLC (AMS), 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 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: / /