



STOCKTON
DERMATOLOGY

MEDICAL RECORD REQUEST

Patient PRINTED Name

Patient ID / SS#

Patient Date of Birth

I hereby authorize:

Name of Physician or Clinic:

Address: _____

City: _____ State: _____ Zip: _____

Phone Number _____ Fax Number: _____

To release to: **STOCKTON DERMATOLOGY** **Toni C. Stockton, M. D.**
 16611 S. 40th St # 100 **Maggie A. Stark, PA-C**
 Phoenix, AZ 85048 **Reena D. Jain, PA-C**
 Phone (480) 610-6366 **Fax (480) 833-1653**

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