SOLANO DERMATOLOGY ASSOCIATES
A MEDICAL CORPORATION

PATIENT AUTHORIZATION FOR REQUEST OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Solano Dermatology Associates to obtain certain protected health information (PHI) about me from _____.

Name of entity to receive this information

The contact information to request it from:

Address: _____

_____

Phone: _____

Fax: _____

This authorization permits Solano Dermatology Associates to request the following individually identifiable health information about me (specify types of reports, chart notes and lab results):

_____

_____.

The information will be used or disclosed for the following purpose:

_____.

This authorization will expire on: _____

{Expiration Date or Defined Event}.

The requested information should be sent to:
Solano Dermatology Associates
Attn: Records Dept.
2290 Sacramento Street
Vallejo, CA 94590

Signed by:_____ _____

Signature of Patient or Legal Guardian Patient's Name

_____ _____

Patient's Date of Birth Today's Date

2290 Sacramento Street
Vallejo, CA 94590
Tel: (707) 643-5785
Fax: (707) 643/5876

480 Chadbourne Rd. Ste 201
Fairfield, CA 94534
Tel: (707) 399-4500
Fax: (707) 399-9410

600 Nut Tree Rd. Ste 360
Vacaville, CA 95687
Tel: (707) 452-7222
Fax: (707) 452-8507

807 St Helena Hwy Ste 2
St Helena, CA 94574
Tel: (707) 963-5450
Fax: (707) 963-1277