SOLANO DERMATOLOGY ASSOCIATES

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Solano Dermatology Associates to use and/or disclose certain protected health information (PHI) about me to _____. This
Name of entity to receive this information
authorization permits Solano Dermatology Associates to use and/or disclose the following individually identifiable health information about me (specify chart notes, reports, labs, etc):
_____
_____.

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

This authorization will expire on _____
{Expiration Date or Defined Event}.
The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

The requested information above should be sent to:

_____
Physician

_____
Address Phone Number

_____ _____ _____
City State Zip Code

Signed by:_____ _____
Signature of Patient or Legal Guardian Patient's Name

_____ _____
Patient's Date of Birth Today's Date

Internal Use Only:

Release of records must be authorized by patient as well as his/her current attending physician at Solano Dermatology Associates.

_____ _____ _____
Print Current SDA Physician Name Signature of SDA Physician 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