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

Vallejo	**Fairfield**	**Vacaville**	**St. Helena**	**Napa**
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	1700 2nd St. Ste. 220 Napa, CA 94559 Tel: (707) 252-2931 Fax: (707) 252-9012