SOLANO DERMATOLOGY
ASSOCIATES

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

Vallejo	Fairfield	Vacaville	St. Helena	Napa
2290 Sacramento Street	480 Chadbourne Rd. Ste 201	600 Nut Tree Rd. Ste 360	807 St Helena Hwy Ste 2	1700 2nd St. Ste. 220
Vallejo, CA 94590	Fairfield, CA 94534	Vacaville, CA 95687	St Helena, CA 94574	Napa, CA 94559
Tel: (707) 643-5785	Tel: (707) 399-4500	Tel: (707) 452-7222	Tel: (707) 963-5450	Tel: (707) 252-2931
Fax: (707) 643/5876	Fax: (707) 399-9410	Fax: (707) 452-8507	Fax: (707) 963-1277	Fax: (707) 252-9012