



SOLANO DERMATOLOGY

A S S O C I A T E S

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

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

Vacaville
600 Nut Tree Rd. Ste 260
Vacaville, CA 95687
Tel: (707) 452-7222
Fax: (707) 452-8507

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

Napa
1700 2nd St. Ste. 220
Napa, CA 94559
Tel: (707) 252-2931
Fax: (707) 603-3895