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 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 260 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) 603-3895