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 Fax 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: 7076435785
Fax: 7076435876

Fairfield
480 Chadbourne Rd., Ste. 201
Fairfield, CA 94534
Tel: 7073994500
Fax: 7073999410

Vacaville
600 Nut Tree Rd. Ste. 260 Vacaville, CA 95687
Tel: 7074527222
Fax: 7074528507

St. Helena
1030 Main St. Ste. 200 St. Helena, CA 94574
Tel: 7079635450
Fax: 7079631277

Napa
1700 2nd St. Ste. 220
Napa, CA 94559
Tel: 7072522931
Fax: 7076033895