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Dermatology
Surgical & Medical Group

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ______________________________ born on ____/_____/____, hereby authorize:
(Name of patient) (Date of Birth)

____
(Name and title or facility name to disclose health information)

____
(Street address, city, state, ZIP code)

____
(Fax number)

to disclose my protected health information including my entire medical treatment record or any protected health information concerning me to:

Dermatology Surgical and Medical Group
1661 Soquel Drive Suite E
Santa Cruz, CA 95065
Telephone: (831) 476-2444 Fax: (831) 476-0705

Please send the following records:

☐ All medical records

☐ Records as specified below only:

____

I understand that by signing this authorization:

My protected health information is to be disclosed under this authorization so the physicians of Dermatology Surgical and Medical Group can reference my medical history in the course of providing medical treatment to me by them.

This authorization shall remain in force for 3 months following the date of my signature below, and a copy of this authorization is valid as the original. I understand I have the right to revoke this authorization in writing, at any time, by sending a written request to DSMG at 1661 Soquel Drive, Building E, Santa Cruz, CA 95065. I understand that a revocation is not effective if any of my providers have relied on this authorization to release information prior to receipt of same. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information at the discretion of the physicians of Dermatology Surgical and Medical Group when deemed necessary.

______________________________________ ______________
Signature of Patient / Guardian Today's Date