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Dermatology
Surgical & Medical Group

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

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

Surgical and Medical Group located at 1661 Soquel Drive Suite E, Santa Cruz, CA 95065, to release the following protected health information:

____

To: ____
(Name and title or facility name to receive health information)

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

________________________ ________________________
(Telephone number) (Fax number)

I would like my records sent via: _____Mail _____Fax _____I am picking up my records

In the event that I am unable to pick-up my records, I authorize ______________________________, to pick-up my records in my absence.

If records are not being picked-up, the undersigned must provide a fax number or mailing address the records are to be sent. Records greater than 25 pages cannot be faxed and must be either mailed to the address listed above or picked-up in office.

I understand that by signing this authorization:

This includes information on the diagnosis or treatment of Human Immuno-deficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco but excludes psychotherapy notes.

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

1661 Soquel Drive Building E, Santa Cruz, CA, 95065 T: (831) 476-2444 F: (831) 476-0705