AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

COMPREHENSIVE DERMATOLOGY GROUP
781 GARDEN VIEW CT, # 201, ENCINITAS, CA 92024
PHONE: 760-634-3376 FAX: 760-634-7955

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substances abuse have special rules that require specific authorization.*

I hereby request access to health information for:

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____

Persons providing information

Name: _____

Address: _____

Phone: _____Fax_____

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

Persons receiving information

Name: _____

Address: _____

Phone: _____ Fax_____

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

DURATION This authorization shall be effective immediately and remain in effect until _____
Date

I have been advised of my right to receive a copy of this authorization.

Print Name: _____Signed: _____ Date:_____

_____
Relationship ***if other than patient***

Office use only

_____Picked up _____Faxed _____Mailed _____Emailed _____Other