AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

TO DERMATOLOGY CONSULTANTS OF SACRAMENTO

Completion of this document authorizes the disclosure of health information about you.

Patient Name _____
Date of Birth _____
Phone number _____

I authorize: _____
(Facility or other provider sending your records)

to disclose my medical records to: Dermatology Consultants of Sacramento
(Facility authorized to receive your records)

at the following address: 5340 Elvas Ave, STE 600
Sacramento, CA 95819
FAX: (916) 739-1426

all of the following information contained in the records specified below:

☐ **THE FOLLOWING RECORDS:**

☐ Office Visit Notes ☐ Lab Reports

☐ Pathology Reports ☐ Medication List

For dates of service:_____

☐ **ALL RECORDS** regarding my treatment.

☐ **BILLING RECORDS**

EXPIRATION OF AUTHORIZATION:_____
(If left blank, this authorization will expire in one year)

PATIENT SIGNATURE:_____ **DATE:**_____