



# DERMATOLOGY

CONSULTANTS OF SACRAMENTO

## 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:** 2410 Fair Oaks Blvd, Suite 220  
Sacramento , CA 95825  
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:** \_\_\_\_\_