AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ______________________, ___ /___/_____ hereby authorize _________________________ to

(Name of Patient) (Date of Birth) (Name of facility which has information)

Release the following health information: ____

____

For the following purposes: ____

____

□ **Outgoing** To: ____

Fax Number or Address:____

□ **Incoming** To: Dermatologist Medical Group of North County, Inc

	Address	Phone Number	Fax Number
□	3613 Vista Way Oceanside, CA 92056	760-758-5340	760-758-5502
□	1200 Gardenview Rd #108 Encinitas, CA 92024	760-942-1311	760-942-6510
□	9850 Genesee Ave #530 La Jolla, CA 92037	858-558-0677	858-558-3077

This authorization is in effect until _____________________(date or event), when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient:	Date
Or Signed by Personal Representative:	Date
On Behalf of (Name of Patient) ____	Relationship/Authority