DERMATOLOGIST MEDICAL GROUP OF NORTH COUNTY, INC.

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.
Phone number: (760) 758-5340
Fax number: (760) 758-5502

By signing this authorization, I understand that:

- This authorization is valid for twelve (12) months from the date of signing.
- I have the right to revoke this authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I authorize the use or disclosure of my individually identifiable health information as described above for the purposes listed.
- I have the right to receive a copy of this authorization.
- Medical records received by Dermatologist Medical Group of North County, Inc. under this authorization may not be further disclosed unless another authorization is obtained from me.

Patient Signature: Date:

Personal Representative Printed Name: Date:

Personal Representative Signature: Relationship/Authority:

Oceanside
3613 Vista Way
Oceanside, CA 92056

Encinitas
1200 Garden View Rd, Suite 108
Encinitas, CA 92024

Carmel Valley
11943 El Camino Real, Suite 220
San Diego, CA 92130