Dermatology Associates Of The South Bay
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name if Applicable: _____ Last four of Social Security #:_____

I request and authorize ***DERMATOLOGY ASSOCIATES OF THE SOUTH BAY*** to RELEASE/RECEIVE my healthcare information to; *(Please check off one of the following)*

- o Self
- o Doctor Office

  Office Name: _____ Address: _____

  City: _____ State: _____ Zip Code: _____

  Office Phone #:_____ Secure Fax #: _____

- o Third Party;

  Full Name: _____ Relationship_____

  (To Be Confirmed By Staff) Driver License/ Identification Number: _____

This request and authorization applies to:

- o Healthcare information relating to the following treatment, condition, or dates:

  _____

- o Labs and or Pathology Reports conducted on the following dates:

  _____

- o All healthcare information
- o Other:_____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.