Dermatology Associates Of The South Bay
Amber A. Kyle, M.D. / Krishna Patel, PA-C
20911 Earl Street, Suite 310
Torrance, CA 90503
Phone: (310) 370-9970 Fax: (310) 370-9973

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

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 (Paper copies may incur charges)

o Personal Fax: _____

o Emailed: (non encrypted or secure): _____

o Doctor's 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:

<u>This request and authorization applies to:</u>

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 90 DAYS AFTER IT'S SIGNED.