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

Completion DATE:

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: (see below) I also understand and agree that I may be financially responsible for the following fees associated with my request: copying charges, supplies, postage related to the production of information. I understand that the charge for this service is, $ __10_ (if I receive paper copies). Photos are __$1___/each.

o Self

o Personal Fax: _____

o Emailed: (non encrypted or secure): _____

o Doctor's Office:

Office Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone #: _____ Secure Fax #: _____

Email: _____

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: _____

o Other: **SLIDES:** I acknowledge it is my responsibility to bring back the slide(s) I received today for my referal appointment, to DR. Kyle's office.

Patient Signature: _____ **Date Signed:** _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT'S SIGNED.