Grossmont Dermatology Medical Center
8860 Center Drive, Suite 300
La Mesa, Ca. 91942
Telephone # 619-462-1670 Fax # 619-462-3209

Medical Authorization Form

Date:_____

Name of patient:_____ Patient's Date of Birth:_____
please print

Address:_____

Daytime Phone Number:_____ Evening Phone Number:_____

I hereby authorize Grossmont Dermatology Medical Center to receive my health information from:

Name of Physician/Facility:_____

Address:_____

Telephone Number:_____ Fax Number:_____

Information to be released:

From & To Dates:_____

( ) Chart Notes
( ) Pathology Report
( ) Lab Report
( ) Chart Notes from other Physicians
( ) Financial Information

Purpose of Disclosure:
( ) Changing Physicians
( ) Patient/Guardian request
( ) Physician request

** I understand that this health information may include HIV/-AIDS related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient_____ Date: _____

Signature of Parent/Legal Guardian/Power of Attorney: _____Date: _____

Relationship to Patient:_____ Date:_____
please print

For Office Use Only

Identification Presented: ( ) Drivers License ( ) Birthdate ( ) Passport
( ) Last Four SS# ( ) Home address

Verified By:

Grossmont Dermatology Medical Center
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Additional providers to request records

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