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:_____ Medical Record Number_____

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

Address:_____

Home #: _____Cell #: _____Fax #: _____

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

Name of Person/Physician/Facility:_____

Address:_____

Telephone #: _____

Information to be released:

From & To Dates:_____

( ) Chart Notes
( ) Pathology Reports
( ) Lab Reports
( ) Chart Notes from other Physicians
( ) Financial information will include your social security number and insurance ID.
Do you want this information removed ( ) yes or ( ) no

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 ( ) Date Of Birth
( ) Last Four SS# ( ) Home Address

Verified By: Copied By: Date Copied:

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Additional records to be released

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