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

Financial Authorization

Date:_____ Medical Record Number:_____

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

Address:_____

Home Phone #: _____ Cell Phone #: _____

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

Name of person receiving records:_____

Address:_____

Home #: _____Cell #: _____Fax #:_____

Indicate method of delivery: (please circle) fax/mail

Financial Information to be released: Purpose of Disclosure: circle below

From & To Dates:_____ Patient/ Power of Attorney/Guardian request

(*) Financial Information includes description of services rendered, your social security number and insurance ID. Do you want this information removed from the form ( ) yes or ( ) no

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:_____

Records Received By:_____ Date: _____
please print

For Office Use Only

Date Copied:	Identification Presented: ( ) Drivers License ( ) Photo ID/Passport Verified with : ( ) Last Four SS# ( ) Home Address ( ) DOB
Copied By:	Verified By: