Solano Dermatology Associates
2290 Sacramento Street
Vallejo, CA 94590

Privacy Issues Protected By HIPAA

Please Initial Items that you are consenting to.

___ I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. (Required Consent)

___ I authorize payment of medical benefits to the physician. (Required Consent)

___ I authorize Solano Dermatology to leave a message on my answering machine regarding lab results/medical information relevant to patient care.

___ I authorize Solano Dermatology to talk to my spouse in regards to my lab results/medical information relevant to patient care.

___ I authorize Solano Dermatology to leave a message on my answering machine regarding account balance information.

___ I authorize Solano Dermatology to talk with my spouse in regards to my account balance information.

___ I authorize the release of my information to a research facility, approved by my provider, if they may be able to help or treat a condition that I have suffered with in my past and/or presently.

___ I acknowledge that the information that I have given to Solano Dermatology is correct and current. Any change and/or additional information will be given to them as soon as possible. If any information is incorrect or lacking, thus resulting in a delay or a denial in billing, I accept responsibility for the outstanding balance. (Required Consent)

_____ _____

Signature if Consent for All Date