SKINPECCABLE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of information from the medical record of:

Last Name	First Name	MI	Date of Birth	Social Security #

Address	Phone #

Information Released To:

Dr. Raphael Darvish
11611 San Vicente Blvd.
Lobby Level
Los Angeles, Ca 90049
T 310.826.2555 | F 310.826.2552

From:

Name _____

Address _____

Phone # _____ Fax # _____

Information Requested:

___ Problem List
___ Progress Notes
___ Medication List
___ History/Physical Exam
___ Consultation Reports
___ Operative Reports
___ Discharge/Transfer Summary
___ Lab Results
___ Pathology Report
___ EKG
___ X-Ray Report
___ Ultrasound Report
___ CT Scan Report
___ MRI Report
___ Echocardiogram
___ Cardiac Stress Test
___ Other: _____

Information To Be:

___ Faxed ___ Mailed ___ Other: _____

I understand this information is confidential and there shall be no further disclosure without the written authorization of the patient or his/her legal representative. This authorization is valid until _____ (one year from date of signature if not specified). I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be disclosed. I understand any disclosure of information carries with it potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Date	Signature	Printed Name	Relationship (if signed by other than patient)

SKINPECCABLE
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