North Valley Dermatology Center

Authorization for Release of Records

I, ____ hereby request and authorize any/all Providers I have received treatment from at North Valley Dermatology Center

To transfer my medical records to:

Name: ____

Address: ____

City & State: ________________________ Zip Code: ________________

Phone: ___________________________ Fax: ______________________

For the following purpose(s):

_______ Continuing Health Care

_______ Other: ____

Medical Records to include:

_______ All records

_______ Specific dates of service: ___________________________

_______ History & Physical Exam _______Surgery Reports _______ Lab _______ Biopsies

_______ Confidential HIV/Hepatitis Lab _______ Other: __________________________

Charges: I understand that you may charge me $0.25 per page plus any additional reasonable clerical costs incurred in making the records available.

_______ I hereby agree to pay the charges specified above. Please bill me.

_______ Please call me to let me know how much these copies will cost.

Signed: ____________________________________ Date: ____________

Print Name: _________________________________Telephone: ________________ Date of Birth: _________

If not signed by then patient, please indicate relationship:

[ ] parent of guardian of minor patient

[ ] guardian or conservator of an incompetent patient

[ ] beneficiary or personal representative of deceased patient

Attention: If you do not leave this form directly with an NVDC staff member please mail it back to us:

251 Cohasset Road Suite 200 Chico, CA 95926