Dermatology Specialists of Pasadena

Authorization for Release of Medical Information

Narineh Zohrabian MD . 800 Fairmount Ave Suite 312 . Pasadena, CA 91105

Patient:_____ **Date:** _____
Address:_____ **DOB:** _____
City/State/Zip:_____ **Phone:**(____)_____

I authorize *Dermatology Specialists of Pasadena* to:

___ Send copies of your record to (or discuss information with) the provider/person/facility below

OR

___ Receive copies of your record from (or discuss your information with) the provider/person/facility below

Name of Provider/Person/Facility: _____
Address: _____
City/State/Zip: _____
Phone:(____)_____ **Fax:**(____)_____

Information to be disclosed:

_____Progress Notes
_____Pathology/Lab Report(s)
_____Operative Notes
_____Cosmetic Notes
_____Entire Medical Record

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request to Dermatology Specialists of Pasadena.

I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative Signature: _____**Date:** _____
Parent/Guardian signature required for minor (less than 18 years of age)
Relationship to patient (if other than self): _____
Printed name of Authorized Representative: _____