Parrish Sadeghi, M.D. at Pure Dermatology and Skin Surgery Center

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Phone: 310-954-9501 Fax: 310-954-9502

Authorization for Use or Disclosure of Medical Record Information

Patient Information

*Patient Full Name:*_____*Date of Birth:*_____

*Patient Address:*_____*Home Phone:*_____

*City:*_____*State:*_____*Zip:*_____*Work Phone:*_____

Release Information To

____*I hereby Authorize Pure Dermatology and Skin Surgery Center to release my medical record information to:*

____*I hereby Authorize the Physician or Facility listed below to release my medical information to Pure Dermatology and Skin Surgery Center, the office of Parrish Sadeghi, M.D.*

___*Mail/Fax Copies To:* ___*Hold for Patient Pick-up* ___*Discuss Medical Information With:*

*Name/Facility:*_____*Attention:*_____

*Address:*_____*Phone:*_____

*City:*_____*State:*_____*Zip:*_____*Fax:*_____

Information to be Released

___*Progress Notes* ___*Laboratory Reports* ___*Pathology Reports*

Duration

This authorization shall be effective immediately and remain in effect for 90 days from the signature date.

Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

*Signature:*_____*Print Name*_____

*Relationship to patient(self, parent, spouse)*_____*Witness*_____