ADVANCED DERMATOLOGY AND COSMETIC CARE

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Make requests Attn: Brittany Holguin

RECORDS RELEASE AUTHORIZATION

In order to process your request for medical records this form must be completed accurately.
By signing below I hereby authorize and request for you to release my medical records to:

❑ Self ❑ Physician/ Provider: _____

Address:_____

_____

_____

Phone: _____ Fax: _____

Specific records that you are requesting:

❑ Specific labs/ biopsy results from: _____ to _____

❑ Specific dates of service: _____ to _____

❑ All records

Brief explanation for records: _____

Per California State Law, fees are allowed for copies. The cost is $15.00 for clerical handling, $0.25 per copy, plus shipping and any applicable tax. For records in storage, there is an additional $46.30 fee for retrieval and re-filing. Please be aware that legally our office has up to 15 days to release medical records. The law also states that the medical physician has the right to substitute a record's summary in place of copies of the actual records.

***Special Fees:** Urgent Demand Authorizations: $35.00 minimum or $25.00 per half hour spent acquiring urgent authorization, whichever is greater. Special forms requiring physician signature: $50.00 minimum or $50.00 per 15 minutes or fraction thereof, whichever is greater. Physician phone calls beyond 10 min: $50.00 per 15 minutes or fraction thereof.*

New Federal Privacy Law (HIPAA) states that we are now allowed to fax medical records.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purposes listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use of disclose the medical information unless another authorization is obtained form me or unless such disclosure is specifically permitted by law.

_____ _____
Patient Signature Date of Signature

_____ _____
Print Name Patient Date of Birth

_____ _____
Patient Phone Number

_____
Patient Address