COASTAL FAMILY
DERMATOLOGY

892 Aerovista Pl Suite 120, San Luis Obispo, CA 93401
P: 805.544.5567 F:805.544.3265

Date: _____

Requested Medical Records should be mailed or **faxed** to:
Please provide Medical Clinic/ Medical Doctor Name, Address & Telephone Number

_____

_____

I hereby authorize you to release the following medical records ***within*** 15 days of receiving this written request according to HIPPA & California State Medical Law.

__ All Records including
__ Last notes & any labs
__ Laboratory _____
__ Operative Report
__ Other

_____ _____
Patient's Name Patient's Date of Birth

_____ _____
Signature of Individual or Parent/Guardian Relationship to patient

HIPPA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the health insurance portability and accountability Act. 45 C.F.R Parts 160 and 164)

- I authorize the healthcare provider listed to use and disclose the protected health information to Coastal Family Dermatology for continuation of medical care of patient
- I authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV OR AIDS, and treatment of alcohol or drug abuse) as well as my additional indicated on this form.
- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct. This authorization shall be in force & effect for one year of the date signed at which time this authorization expires.
- I understand that I have the right to revoke this authorization in writing at any time
- I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on the authorization or if the authorization was obtained as a condition or obtaining insurance coverage and the insurer has a legal right to contest a claim