El Segundo Dermatology

MEDICAL RECORDS—RELEASE OR ACQUISITION

Without your written consent, we are not able to release or obtain records from other providers.

I authorize El Segundo Dermatology to: ❐ obtain my medical records
❐ release my medical records

Name of practice, facility or provider: ______________________________

Patient Name: ______________________________ DOB: ______________

TYPE OF INFORMATION TO BE RELEASED

- ❐ Billing Statements
- ❐ Pathology Reports
- ❐ Progress Notes
- ❐ Laboratory Reports
- ❐ Operative Reports
- ❐ Other ______________________________

Specify the date or time period for information selected above: ______________________________

THE PURPOSE OF THIS RELEASE IS

- ❐ At the request of the patient/patient representative
- ❐ Other (state reason) ______________________________

NOTICE

We at El Segundo Dermatology are required by law to keep your health informational confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

- I understand this authorization is voluntary.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to El Segundo Dermatology, 713 N. Douglas St., El Segundo, CA 90245. The revocation will take effect when El Segundo Dermatology receives it.
- I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires____________________ (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

Signature: ______________________________ Date: ______________
(Signature of Patient or legal guardian)

Name of guardian: ______________________________ Relationship: ______________

Phone Number: ______________________________ Witness: ______________