San Luis Dermatology & Laser Clinic, Inc.

15 Santa Rosa Street – San Luis Obispo, CA 93405 ~ Phone: (805) 541-2650 Fax: (805) 541-4043

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ________________

- I request San Luis Dermatology & laser Clinic, Inc. to make a copy my medical record(s). I understand there may be a charge for copying records, which may also include postage if mailed to me directly.

  Please select pick-up, or other delivery method below:

  Pick-Up ☐ **Personal Fax** ☐ **Standard Mail** ☐

  Fax#: ______________________________

  Name: ______________________________

  Address: ______________________________

  City: ________________ State: ______ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information related to following Treatment, Condition, or Date: ________________

☐Summary of History, findings, and diagnoses ☐ Laboratory Reports ☐Pathology Reports

☐ All healthcare information

*Please allow 3-5 business days for standard copying of records. Please let the office know if there is an urgency in retaining a copy of your records and we will try our best to expedite your request.

Patient Signature: ______________________________ Date: ________________

THIS AUTHORIZATION EXPIRES THIRTY DAYS AFTER IT IS SIGNED.

The PHI (Personal Health Information) contained in the FAX is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such. If you have received this facsimile in error, please notify us at (805) 541-2650 and return the original message to the address above via mail.

Updated 5/21/14 MT