The Dermatology Center at Ladera
600 Corporate Drive, Suite 240
Ladera Ranch CA 92694-2111
Phone: 949-364-8411
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Medical Record Release Authorization

Patient Name_____Maiden Name_____SS#_____

Date of Birth_____Cell Phone_____Home_____

Address_____City/State/Zip_____

Email Address: _____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone#_____Fax#_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone#_____FAX#_____

C) For the purpose of:

_____ Litigation
_____ Disability
_____ Insurance
_____ Work Comp
_____ Self/Personal Copy
_____ Other
_____ Transfer or Continuity of Care

Date Range_____to_____

☐ Physician Office Notes
☐ Lab/Path Reports
☐ Operative/Procedure Reports
☐ Minimum Necessary ☐ Other _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

We reserve the right to charge the medical record state fee structure as set forth in the state statue.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____****Subject to Fees**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____

(Expiration date of authorization)

FOR OFFICE USE ONLY

REQUEST FULFILLED (DATE/TIME): _____ METHOD: _____ INITIALS: _____