Newport Skin Cancer
1100 Quail St., Ste 102
Newport Beach, CA 92660
Phone: (949) 336-7171
Fax: (949) 336-7172

Medical Record Release Authorization

Patient Name________________________________Maiden Name_________________SS#___________

Date of Birth______________ _____ Home Phone _____________________Cell___________________

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:

_________ Personal
_________ Disability
_________Insurance
_________ Worker's Comp
_________ Legal
_________ Transfer of Care

Date Range________________ to ________________

☐ Physicians Office Notes
☐ Lab/Path Reports
☐ Operative/Procedure Reports
☐ Other

D) Records Format:

☐ Please send printed copies via postal mail

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 assure treatment. I understand that any disclosure of information carries with it the potential for an authorized 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.

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

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

This authorization will expire one year from the above date unless I specify an expiration date:
________________________ (Date: Month/Year)