Reset All Fields

COASTAL ALLERGY CARE
Caring Accessible Excellence

Lewis J. Kanter, M.D.
Cristina N. Porch-Curren, M.D.
Christine Y. Lee-Kim, DO
Diplomate Of The American Board Of Allergy & Immunology
And Associates
• Camarillo 805-482-8989; FAX (805) 987-2855
• Thousand Oaks (805) 493-1537
• Simi Valley (805) 581-6482

REQUEST/AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Use this form to obtain patient authorization for disclosure where authorization is required.

I, _____ **(patient),** _____ **(date of birth)** hereby authorize *Coastal Allergy Care* the use or disclosure of the following protected health information for continued healthcare or further evaluation:

◯ **Disclose my medical information to_____, relationship _____**

◯ **I will pick up my records (paper) at one of the following offices (circle one): ○CAM ○TO ○SIMI**

◯ **I prefer my information supplied on a USB, the USB is provided by CAC, *I will pay the $25 fee at the time of the request is submitted* and will pick up my records at (circle one): ○CAM ○TO ○SIMI**

◯ **Radiography/Xray Records ONLY**

◯ **Lab Test Records ONLY**

◯ **Allergy Skin Test Record ONLY**

◯ **Antigens/Shot Records ONLY**

◯ **Last Office Visit Notes ONLY**

Please OBTAIN information FROM	**Please SEND information TO**
Name: _____	**Name:** _____
Address: _____	**Address:** _____
City, State, Zip: _____	**City, State, Zip:** _____
Telephone: _____	**Telephone:** _____
Fax: _____	**Fax:** _____

ATTN: Privacy Officer

I understand that I may revoke this authorization, in writing, at any time by sending written notification to *Coastal Allergy Care* at *2412 Ponderosa Drive North, Suite B111, Camarillo, California 93010.* I understand that information used or disclosed by the practice as permitted by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that the practice may not condition my treatment on whether I sign this authorization for the requested use or disclosure. I understand that I have the right to Inspect or copy the protected health information that will be used or disclosed under this authorization, to the extent permitted under federal law (or state law to the extent the state law provides greater access rights.) I understand that I have the right to Refuse to sign this authorization.

_____ _____

Print Patient Name or Personal Representative **Signature of Patient or Personal Representative**

Date: _____ **CAC Staff/Completed by** _____