Reset All Fields

COASTAL ALLERGY CARE
Caring Accessible Excellence

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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:

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

◯ **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**

☐ **Radiography/Xray Records**

☐ **Lab Test Records**

☐ **Allergy Skin Test Record**

☐ **Antigens/Shot Records**

☐ **Last Office Visit Notes**

Please OBTAIN information FROM

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Fax: _____

Please SEND information TO

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

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** _____