

**California Medical Records Release Authorization**

By signing below, I hereby authorize and request for you to release my medical records to:

q Self or

Physician/ Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific records that you are requesting:

q Labs/ Biopsy Results/Slides

Specific dates of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

q All records

Specific dates of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explanation for records request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Per California State Law, fees are allowed for copies. The cost is $35.00 for clerical handling, $0.25 per page, plus shipping and any applicable tax. For records in storage, there is an additional $46.30 fee for retrieval and re-filing. Please be aware that legally our office has up to 15 business days to release medical records. The law also states that the medical physician has the right to substitute a record’s summary in place of copies of the actual records.*

**Business and Professions Code §2266 requires physicians to maintain adequate and accurate medical records for a minimum of 7 years, any records exceeding that time frame are given at the discretion of the physician. I understand the practice may decline to release records dating back further than 7 years.**

I understand that by signing this authorization:

* I authorize the use or disclosure of my individually identifiable health information as described above for the purposes listed.
* I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. Any revocation requested must be made in writing and will not affect information that has already been used or disclosed.
* I understand that there is a fee for this request
* I have the right to receive a copy of this authorization.
* I am signing this authorization voluntarily and treatment, payment or my eligibility for benefits will not be affected if I do not sign this authorization.
* I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use of disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically permitted by law.

Patient Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_