peninsula dermatology medical group, inc.

1750 EL Camino Real, Suite 206 ▪ Burlingame, CA 94010 ▪ Phone: (650) 692-0182 ▪Fax: (650) 692-8116

Authorization to Release / Obtain Patient Health Information

Please Note: For ANY/ALL chart storage retrieval fee will be $75 + fee for copy of the medical records. You will be contacted if there are any fees due prior to requesting retrieval or copy fees.

I hereby authorize Peninsula Dermatology Medical Group, Inc. to release / obtain my medical information as listed:

Patient Name: _____ DOB: _____

Address: _____

Phone Number: _____ Email Address: _____

Obtain From:

_____
Name

_____
Address

_____
City, State and Zip

_____
Phone / Fax

Release To:

_____
Name

_____
Address

_____
City, State and Zip

_____
Phone / Fax

Information Requested:

□ Entire Medical Record □ Last Exam
□ Lab Results □ Pathology Results
□ Other _____

Specific Dates:

From: _____To: _____

I understand that this authorization is valid for 90 days and may be revoked in writing at any time prior to 14 days by notifying medical records.

_____ _____ _____
Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian | Date of Request

Office Use Only:
Fee: □ *$* _____ □ *N/C*

Reviewed and Approved to be released by: _____
MD initials and Date

Date records mailed / e-faxed: _____