AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS INFORMATION

EXPLANATION:

PATIENT NAME: _____ **Birthdate:** _____

Treatment Date (s): _____

INFORMATION TO BE RELEASED FROM:

HK Dermatology
Jeffrey Alan Klein, M.D., Inc.
30280 Rancho Viejo Road
San Juan Capistrano, CA 92675
TEL: (949) 248-1632

INFORMATION TO BE RELEASED TO:

NAME/AGENCY: _____

ADDRESS: _____

PURPOSE FOR RELEASE: _____

INFORMATION TO BE RELEASED:

(1) Clinical progress notes

(2) Lab reports

(3) Surgical procedure notes

Other (specify) _____

_____

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 19 81, Section 56 et seq., California Civil Code.

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires ___ days from the date of SIGNING.

I am aware of and/or have been advised of the provisions of existing State and Federal Statutes, Rules and Regulations which provide for my right to confidentiality of the information in this records. I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released, and that I may refuse to sign, but in that event the records cannot be released. I further release my attending physician, consultants, the facility and employees from any liability arising from the release of information to the person(sl/agency designated above. I understand that I have a right to receive a copy of this authorization upon my request.

*A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a non-profit hospital plan, a health care service plan or an employee benefit plan.

DATE: _____ **DATE:** _____

_____ _____

SIGNATURE OF PATIENT/GUARDIAN/REPRESENTATIVE **SIGNATURE OF PATIENT**