

PENINSULA DERMATOLOGY MEDICAL GROUP, INC.

Diseases of the Skin · Dermatologic Surgery · Laser Surgery · Mohs' Surgery

1750 El Camino Real #206, Burlingame, CA 94010

Tel (650) 692-0182 Fax (650) 692-8116

To Whom It May Concern:

Our office recently received a request from (patient/insurance company) for medical history records. Due to the current **HIPPA** guidelines, every step to ensure the privacy of our patients must be taken.

Please see the attached Peninsula Dermatology Medical Release Form that our office requires to be signed and completed by the patient. This will authorize our office to release any and all requested information to the authorized party.

Charts for patients not seen in the last **FOUR** years are in storage. The storage facility, in which the charts are housed, have a service fee for pulling, delivery and returning these records. Also additional time is needed to obtain these records.

Please note and initial:

- _____ There will be "no charge" for less than 3 pages copied.
- _____ Any amount of pages exceeding 3 requires a \$25.00 fee.
- _____ Charts in storage fee is \$75.00

Please enclose a check made payable to:

PENINSULA DERMATOLOGY

Thank you for your prompt attention.

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Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize Peninsula Dermatology to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Peninsula Dermatology to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, type of services, level of detail to be released, origin of information, etc. _____
_____.

The information will be used or disclosed for the following purpose: _____
_____.

If requested by the patient, purpose may be listed as "at the request of the individual". The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. The authorization will expire on (expiration date or defined event) _____.

The Practice will___will not___ receive payment of other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Peninsula Dermatology. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 1750 El Camino Real, Ste. 206, Burlingame, CA 94010.

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Patient's Name Date

Print Name of Patient or Legal Guardian Date of Birth of Patient

***PATIENT/GUARDIAN TO BE PROVIDED A SIGNED COPY OF AUTHORIZATION
PLEASE RETURN THIS SIGNED FORM EITHER BY FAX OR MAIL***