Southern Marin Dermatology

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

I, ___________________________/ DOB:_________________________

☐☐ My entire medical or record
☐☐ Test Results only (pathology and labs)
☐☐ Portions of my Medical Record, specifically: ______________________________
☐☐ Date-specific Portions of my Medical Record, From Date:________________To Date: ________________

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

I specifically authorize this Practice to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***super-confidential information*** as stated in the NOPP (initial where appropriate): Initials

☐☐ HIV records (including HIV test results) and sexually transmissible diseases _______
☐☐ Alcohol and substance abuse diagnosis and treatment records _______
☐☐ Psychotherapy records _______
☐☐ Not Applicable

REQUIRED TO COMPLETE:

In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request.

Please release my records **FROM** (please print clearly):

Third Party/Facility Name: Southern Marin Dermatology Fax: 415.887.9763
Address: 2330 Marinship Way, Suite 370
City: Sausalito State: CA Zip: 94965
Date of this request: ____________________

Please release my records **TO** (please print clearly):

Third Party/Facility Name:______________________________ Fax________________
Address:________________________ City: ____________ State: ________ Zip:____________
Date of this request: ____________________

Patient Name (please print): ______________________________________

Signature:____Date: ______________

OR

Patient's Legal Representative's Name (please print): ______________________________

Signature:____Date: ______________
Describe Authority:____

OFFICE USE ONLY

Describe what alternative communications were denied this____________day of______________, 20________

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Describe what alternative communications were accepted this____________day of______________, 20________

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