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:_____Fax:_____
Address:_____City: _____ State: _____ Zip: _____
Date of this request: _____

Please release my records **TO** (please print clearly):
Third Party/Facility Name: Southern Marin Dermatology_____ Fax: 415-887-9763_____
Address: 2330 Marinship Way, Suite 370 State: CA Zip: 94965
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_____
_____
Describe what alternative communications were accepted this_____day of_____, 20_____
_____