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

Patient Information

Last Name: _____ First Name: _____ Date of Birth: _____

Street Address: _____ City/State/Zip: _____

I hereby authorize Southern Marin Dermatology, located at 2330 Marinship Way, Suite 370, Sausalito, CA 94965, to release my medical records as follows: *(at least one option must be selected for this form to be valid)*

- ☐ My entire medical record
- ☐ Test results only (pathology and/or labs) ☐ HIV test results _____ (initial)
- ☐ Portions of my medical record, specifically:_____
- ☐ Date-specific portions of my medical record, from _____(date) to _____(date)

Purpose for Release of Use of the Information

☐ Health Care ☐ Personal Use ☐ Legal ☐ Other (specify): _____

Individual / Organization to Receive the Information

Name of Patient or Third Party/Facility: _____

Address:_____

City: _____ State: _____ Zip: _____

Fax: _____

I understand the following:

1. I authorize the use/disclosure of my individually identifiable protected health information for the purpose(s) listed.
2. I am signing this authorization voluntarily and understand that my health care treatment will not be affected if I do not sign.
3. Unless otherwise specified, medical records released as part of this authorization may contain references related to mental health, substance use disorders, medication assisted treatment, genetic testing, communicable or sexually transmitted disease, and HIV medical conditions, if any such information has been provided to Southern Marin Dermatology. Southern Marin Dermatology does not maintain alcohol/substance abuse diagnosis and treatment records or psychotherapy records.
4. Under California law, the recipient of the protected health information is prohibited from rediscussing the protected health information, accept with a written authorization or a specifically required or permitted by law.
5. If the organization or person authorized to receive the protected health information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.
6. Reasonable fees may be charged to cover the cost of related copying and postage expenses.
7. I have the right to inspect or obtain a copy of the health information that I am being asked to allow the use/disclosure of.
8. I have the right to receive a copy of this authorization.
9. I have the right to revoke this authorization at any time by submitting a request in writing.
10. I hereby release, hold harmless, and agree to indemnify Southern Marin Dermatology and its employees and agents for any and all liability arising out of this consent.
11. This consent form shall expire _____ (date), or one year from the date signed if not otherwise indicated.

Signature: _____ Date: _____

If signed by a person other than the patient:

Name of Patient's Legal Representative (please print): _____

Describe Relationship and Authority: _____