



1941 Johnson Ave, Ste 101  
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## Medical Records Release

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
MM/DD/YYYY  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

Coastal Cardiology may **OBTAIN** copies of my records listed below from:

1. (Physician or facility which has health information)	2. (Physician or facility which has health information)
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____ Fax: _____	Phone _____ Fax: _____

Coastal Cardiology may **RELEASE** copies of my records listed below to:

1. (Physician or facility to receive health information)	2. (Physician or facility to receive health information)
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

<input type="checkbox"/> Consultation (date) _____	<input type="checkbox"/> Event Recorder (date) _____	<input type="checkbox"/> Holter (date) _____
<input type="checkbox"/> Progress note (date) _____	<input type="checkbox"/> Hospital Reports (date) _____	<input type="checkbox"/> Cath/PCI (date) _____
<input type="checkbox"/> Stress echo (date) _____	<input type="checkbox"/> Echocardiogram (date) _____	<input type="checkbox"/> ECG (date) _____
<input type="checkbox"/> Nuclear Stress (date) _____	<input type="checkbox"/> Lab Reports (date) _____	<input type="checkbox"/> Copy of All Records (up to 7 yrs)
<input type="checkbox"/> Other _____		

**I AUTHORIZE THE RELEASE OF ALL INFORMATION AND I AM AWARE THAT THE RECORDS RELEASED MAY CONTAIN CONFIDENTIAL INFORMATION RELATING TO PSYCHIATRIC OR PSYCHOLOGICAL TESTING, PHYSICAL ABUSE OR DRUG/ALCOHOL ABUSE.**

**CHECK HERE TO EXCLUDE CONFIDENTIAL INFORMATION**

X \_\_\_\_\_  
**Patient's Signature**                      **Date**                      **Signature of Witness**

If Individual is unable to sign this Authorization, please complete the information below:

\_\_\_\_\_  
**Name of Guardian/Representative**      **Legal Relationship**                      **Date**

**THIS AUTHORIZATION EXPIRES ONE YEAR AFTER DATE SIGNED**

THE INFORMATION CONTAINED HEREIN IS PROHIBITED FOR USE FOR OTHER THAN THE STATED PURPOSE.

## GUIDELINES FOR PATIENT ACCESS TO MEDICAL RECORDS

AB610, sections 25250-25258 of the California Health and Safety Code, provides that any adult, any minor patient authorized by law to consent to the treatment to which the record pertains, or any patient's representative is entitled to inspect the patient record or obtain copies.

1. The Medical Record Department will be responsible for responding to ALL requests for patient access.
2. The Medical Record personnel will not attempt to explain or interpret anything in the record.
3. Request must be in writing, must provide sufficient information to identify the patient and include appropriate payment.
4. Copies will be completed within fifteen (15) days of receipt of a valid written request. The request must specify records desired.
5. Inspection may be carried out by appointment, during business hours (9:00 a.m. to 4:00 p.m.) Monday through Friday, except for Holidays.
6. Inspection will be carried out under the direct visual supervision of the Medical Record Supervisor.
7. Reasonable effort to establish the identity of the patient or patient's representative will be made prior to inspection or provision of copies. Persons requesting access as guardians or conservators MUST present evidence of appointment.
8. One individual may accompany the patient or representative during the inspection.
9. Records will be made available for inspection by the patient or patient's representative within five (5) working days of receipt of written request.
10. Summary Option may be exercised upon physician discretion.
11. Fee Schedule:

Clerical	\$16.00 (\$4 per 114 hour)
Inspection	\$5.00
Reproduction	
Per Page	\$.25
Per Microfilm Image	\$.50
X-ray Films	
Per Sheet	\$10.00
Postage	Actual Cost

Medical Records sent directly to another physician or medical facility will have reproduction fee discounted as a professional courtesy