

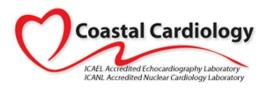
Medical Records Release

1941 Johnson Avenue Suite 102 San Luis Obispo, CA 93401 805-782-8844 phone 805-782-8859 fax www.coastalcardiology.com

Please read this form in full before completing it. This release is in 14-point font per Cal Civ Code §56.11. **Bold fields** are mandatory and incomplete forms cannot be processed.

| Name: | Date of Birth: |
|--|---|
| Phone: | _ Account #: |
| Address: | |
| I hereby authorize Coastal Cardiology to: | |
| ☐ Release To (Who Needs Records) | or Request From (Who Has Records) |
| Name: | |
| Phone: | _ Fax: |
| Address: | |
| Purpose for Release: □Continuing Care A | appointment on |
| | Other: |
| The following information is to be disclos | |
| - | monary testing including EKGs (within 2 years) |
| | □Event Recorder/Holter: |
| □Echo: | _ □ECG: |
| ☐Hospital Reports: | |
| □Stress Test: | Other: |
| I understand that: | |
| Digital records may be sent via disk, th | numb drive or secure email to |
| | of psychiatric conditions, drug/alcohol abuse, or |
| • | quest the exclusion of confidential information |
| • My right to healthcare treatment is no | |
| | time by submitting a written request, but |
| revocation will not apply to the inform | |
| • • • | formation is not covered by federal privacy |
| | nger be protected and may be re-disclosed. |
| This authorization expires one (1) year | |
| | medical records (see reverse for details). |
| | as the original. I have a right to a copy. |
| The copy of this authorization is as valid a | as the original. Thave a right to a copy. |
| Patient/Representative's Signature | e Date |
| ⊃ If you are not the patient, documentat | ion of your signatory authority is needed. |
| Print your name | |
| ☐ Parent/Guardian ☐ Beneficiary/Conse | rvator/Representative \square Other: |
| INTERNAL USE ONLY: Received by ☐ Patient Pi | icking Up □ Mail to Patient □ Given to Patient |

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Guidelines for Patient Access to Medical Records

Section 123100-123149.5 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 representatives 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 ten (10) business days of receipt of a valid written request. The request must specify the desired records.
- 5. Inspection may be carried out by appointment during business hours (9:00am-4:00pm) Monday through Friday, except holidays.
- 6. Inspection will be carried out under the direct visual supervision of the Medical Records Supervisor.
- 7. Reasonable efforts to establish the identity of the patient or the patient's representative will be made prior to inspection. Persons requesting access as guardians or conservators *must* present documentation to prove their authority.
- 8. One individual may accompany the patient or representative during the inspection.
- 9. Records will only be made available for inspection by the patient or patient's representative within five (5) working days of receipt of a written request.
- 10. Summary option may be exercised upon the discretion of the physician.

11. Fee Schedule:

| Clerical | \$16.00 (\$4.00 per ¼ hour) | |
|--|-----------------------------|--|
| Inspection | \$ 5.00 | |
| Reproduction Per Page | \$.25 | |
| Study Images or Electronic Format | \$25.00 | |
| Postage | Actual Cost | |
| All medical records sent directly to another physician or medical facility | | |
| are a professional courtesy. | | |