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Authorization for Use or Disclosure of Protected Health Information (Release of Information)

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice Practices without your authorization. Your completion of this form means that you are giving us permission for the uses and disclosures described below.

I hereby authorize: **Coast Dermatology, James R Kunkel, MD**

To release copies of all medical records compiled during office visits and/or hospital admissions.

Patient: _____
DOB: _____
Phone #: _____

Release medical records to: _____
_____
_____
_____

Purpose or need for information: To continue medical care/treatment.

This consent will expire 1 year after the date below or sooner at my election.

I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, psychiatric disorders, or HIV infection.

Date: _____ Signature: _____

Relationship: _____