Instructions For Obtaining Medical Records

In order to obtain medical records, the attached Medical Records Release Form must be signed by the patient (guardian if a minor) or have a Power of Attorney.

The signed Medical Records Release Form may be submitted in person at the office, by email to coastdermatology1@gmail.com, or via fax to 805-474-9552.

Patients may authorize another individual to pick up their records; however, this authorization must be indicated on the release form.

Records may EITHER be copied for patient pickup at the office, or faxed to another medical office where the patient has a scheduled appointment.

Patients will be notified once their medical records are ready. Please allow up to 2 weeks for preparation of your medical records.

The last day to pick up records will be June 30, 2026.

Our office will remain open through July 14, 2026, for any urgent matters. Routine appointments will not be scheduled during this time.

Office hours: M-Th, 8:00-4:30, closed for lunch 12-1:15.

JAMES R. KUNKEL, M.D., Inc.
880 Oak Park Blvd., Suite 103 Arroyo Grande, CA 93420
Phone: (805) 474-9550 Fax: (805) 474-9552

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: _____