Medical Records Release

Coastal Cardiology
ICAEL Accredited Echocardiography Laboratory
ICANL Accredited Nuclear Cardiology Laboratory

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

Name: _____ Coastal Cardiology Physician: _____
Phone: _____ Date of Birth: _____ Account #: _____
Address: _____ City: _____ State: ___ ZIP: _____

PLEASE READ THIS FORM THOROUGHLY BEFORE COMPLETING IT!
ALL **BOLD** FIELDS ARE REQUIRED. INCOMPLETE/INCORRECT FORMS CANNOT BE PROCESSED.

I hereby authorize Coastal Cardiology to:

☐ **Release To** (Who Needs Records) or ☐ **Request From** (Who Has Records)
Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: ___ ZIP: _____

☐ **Release To** (Who Needs Records) or ☐ **Request From** (Who Has Records)
Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: ___ ZIP: _____

Purpose for Release: ☐ Continuing Care Appointment on _____ ☐ Insurance/Attorney
☐ Other: _____ ☐ Personal Use

The following information is to be disclosed (dates are required):
☐ Last 2 progress notes, last 2 labs, plus cardiac or pulmonary testing including EKGs (within 2 years)
☐Consult/Progress Note:_____ ☐Event Recorder/Holter: _____
☐Echo: _____ ☐ECG: _____
☐Hospital Reports: _____ ☐Lab: _____
☐Stress Test: _____ ☐Other: _____

I understand that:

- Electronic format records may be sent via disk, thumb drive or secure email to _____.
- The information released may include documentation of alcohol abuse, psychiatric condition, drug abuse or communicable disease. ☐ Check here to request the exclusion of all confidential information.
- My right to healthcare treatment is not conditioned on this authorization.
- I may revoke this authorization at any time by submitting a written request to the address at the top of this form but revocation will not apply to the information that has already been released.
- If the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
- This authorization expires one (1) year after it is signed.
- There may be a charge for requesting medical records *(please see the reverse of this page for details)*.
- A copy of this authorization is as valid as the original. I have a right to receive a copy of this document.

➲_____
Patient/Personal Representative's Signature **Date**

➲**If you are not the patient, print your name**: _____
and indicate your relationship: ☐ Parent/Guardian ☐ Deceased Patient's Beneficiary/Personal Representative
☐ Incompetent Patient's Guardian/Conservator *Note: Documentation of your signatory authority is required.*

INTERNAL USE ONLY:
Received by _____ ☐ Patient Picking Up _____ ☐ Mail to Patient ☐ Given to Patient
Print name *Date*

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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 copies of documentation to prove the 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.	