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REQUEST FOR TRANSFER OF HEALTH 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 of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the transfer of health information described below. Please review and complete this form carefully. It may be invalid if not fully completed.

I hereby request the transfer of health information for:

_____

(Print patient's name and address)

RECORDS TO BE TRANSFERRED:

I would like the following transferred:

[ ] All the records or [ ] The portion of the records concerning: _____

_____

(Specify the dates of treatment needed)

PLEASE TRANSFER THESE RECORDS TO: _____

_____

(Name & address **OR FAX NUMBER** of health care provider to whom the records are to be delivered.)

CHARGES: I understand that you may charge me a reasonable charge of up to $0.25 per page, a retrieval fee of $3.20, postage, and any additional reasonable clerical costs incurred in making the records available.

[ ] I hereby agree to pay the charges specified above. Please bill me.

[ ] Please call me to let me know how much these copies will cost.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

[ ] parent or guardian of minor patient

[ ] guardian or conservator of an incompetent patient

[ ] beneficiary or personal representative of deceased patient