Request for Records Release

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.

AUTHORIZATION: I hereby authorize the office of _____. To release information on _____ (Patient's Name) _____ (Patient's DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

TO:

Dr. Karin I. Harp, MD, FAAD / Kristin N. Rupert, PA-C, MS, MPH / Sherri N Anderson, MS, PA-C

32144 Agoura Road, Suite 112 Westlake Village, CA 91361

Fax: (818) 889 - 2747 **/** Office: (818) 889 – 2739

The medical information/records will be used for the following purpose:

Medical Care

This authorization is: [ ] Unlimited (all records, excl Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information:

_____

_____

Patient Preference:

_____ Past year (if multiple visits in one year) or past two chart notes, pathology reports, surgical op notes.

_____ Complete records

_____ Other: _____

DURATION: This authorization shall be effective immediately and remain in effect until_____ (Date).

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization. Thank you,

_____	_____
Signature of patient *or legal/personal rep. patient*	Relationship *if other than*
_____	_____
Patient name (print)	Date
_____	_____
Patient's Social Security Number	Patient's Date of Birth
_____	_____
Witness name	Witness signature