

## Perlman Clinic Release of Information / Medical Records Request

Attn: Medical Records Department 3900 5<sup>th</sup> Ave Suite 300 San Diego, CA 92103

(P): 858-554-1212 (F): 858-795-1195

PLEASE NOTE: If you submit this form online, it will automatically be emailed to <a href="medicalrecords@perlmanclinic.com">medicalrecords@perlmanclinic.com</a>. Please be advised that email is not secure for HIPAA-protected information. To send this securely, please print it and fax it to 858-795-1195. It is the policy of this medical practice that we will adopt, maintain, and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California Law.

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Date of Birth:	Patient's Legal Nam	e:		Patient's Phone Number:	
I request a convent the	following modical roc	First  Ords*** (+bo "Modical Pocords") b	Middle		
I request a copy of the following medical records*** (the "Medical Records") be:					
ONLY CHOOSE ONE  Delivered to Berlman Clinis by the below listed Easility/Derson					
<ul> <li>Delivered to Perlman Clinic by the below listed Facility/Person</li> <li>Faxed by Perlman Clinic to the below listed Facility/Person</li> </ul>					
Emailed by Perlman Clinic to the below listed Facility/Person: The delivery of Medical Records by use of email is not					
secure for HIPAA-protected information. Nevertheless, I am instructing Perlman Clinic to email my Medical Records to					
the following email, and I assume all risks thereof and agree to hold Perlman Clinic harmless: Initials					
***Note: We can only release Perlman Clinic records. If you have sent us outside records, we cannot release these to other facilities. You will need to request the release of those records directly from the original facility.					
With out Limitation. Complete modical records shall be muchided including without limitation. Dispers Depart(s) and					
Limited to the following: (Please check)					
<ul> <li>□ Discharge Summary</li> <li>□ History/Physical</li> <li>□ Progress Notes</li> <li>□ Lab Tests</li> <li>□ X-Ray/Imaging Reports</li> <li>□ Billing Records</li> <li>□ Other:</li> </ul>					
***Note: If these records contain any information from previous providers or information about HIV/AIDS status, mental health/psychiatric					
records, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.					
Facility/Person:		Phone Number:	Fax Number:	Fax Number:	
racinty/rerson.		Thore Number.	Tax Ivalliber.		
Address:					
Stroot		City	Chaha		
Street Email Address:		City	State Zip		
I release Perlman Clinic and the Facility/Person from any claim and liability that may arise from the release of the Medical					
Records. I further understand that this Authorization is voluntary and that I may refuse to sign this Authorization. My refusal					
to sign will not affect my ability to obtain treatment; or receive payment or eligibility for benefits unless allowed by law. By					
signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of					
protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or					
otherwise restrict my ability to authorize the use or disclosure of this protected health information. Upon written request, you					
may request a copy of this Authorization and/or revoke this Authorization (except to the extent that action has been taken in					
reliance thereon).					
Signature of Patient or Parent/Guardian/		Printed Name of Patient or Patient		authorization will expire one the above date.	