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Request for transfer of medical records

As required by Health Information Portability and Accountability Act of 1996 (HIPPA) and California law, this practice may not use or disclose your individually indentifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means you are giving permission for the transfer of health information described below. Please review and complete the 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: ( ) All the records ( ) Specify the portion of record needed \_\_\_\_\_

PLEASE TRANSFER RECORDS TO: \_\_\_\_\_

\_\_\_\_\_  
(Name and address of person or provider to whom records will be sent)

CHARGES: No charge for first copy. Subsequent copies will be \$0.25 per page. ( ) I agree to pay the charges. Please bill me.

( ) Please call me to let me know how much these will cost.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name : \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate your relationship

- ( ) parent or guardian of minor ( ) guardian of incompetent patient  
( ) beneficiary or representative of deceased patient