Grossmont Office:
8860 Center Drive, Suite 300
La Mesa, CA 91942
(P): 619-462-1670
(F): 619-462-3209

San Diego Office:
5500 Carmel Mountain Road, Suite 206
San Diego, CA 92130
(P): 858-943-2540
(F): 858-252-2053

Encinitas Office:
477 N. El Camino Real, Suite C300
Encinitas, CA 92024
(P): 760-257-5550
(F): 858-252-2053

Medical Records Authorization Form

Date:_____

Name of patient:_____ Patient's Date of Birth:_____

Address:_____

Phone Number: _____

I hereby authorize Coastal Skin & Eye Institute to release my health information to or receive my health information from:

Name of Physician/Facility:_____

Address:_____

Phone Number:_____ Fax Number:_____

Information to be released:

From & To Dates:_____

( ) Chart Notes
( ) Pathology Report
( ) Lab Report
( ) Chart Notes from other Physicians
( ) Financial Information

Purpose of Disclosure:
( ) Changing Physicians
( ) Patient/Guardian request
( ) Physician request

** I understand that this health information may include HIV/-AIDS related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient_____ Date: _____

Signature of Parent/Legal Guardian/Power of Attorney: _____Date:_____

Relationship to Patient:_____Date:_____

For Office Use Only

Identification Presented: ( ) Drivers License ( ) Birthdate ( ) Passport
( ) Last Four SS# ( ) Home address
Verified By: