



**Grossmont Office:**

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

**Carmel Valley Office:**

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

**Encinitas Office:**

489 Saxony Place, Suite 101  
Encinitas, CA 92024  
(P): 760-257-5550  
(F): 858-252-2053

**Medical Records Authorization Form**

**Date:** \_\_\_\_\_

Name of patient: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

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

Name of Patient/Physician/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Information to be released:

Purpose of Disclosure:

From & To Dates: \_\_\_\_\_

- Changing Physicians
- Patient/Guardian request
- Physician request

- Chart Notes
- Pathology Report
- Lab Report
- Chart Notes from other Physicians
- Financial Information

**\*\* 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: \_\_\_\_\_

**Records sent by fax or our messaging system, Klara, are no charge. Records that need to be printed and/or mailed will be \$0.25 per page. Payment is due when form is submitted.**