



Request for Release of Protected Health Information

Patient Name: _____ Date of Birth _____ Phone: _____
(Please Print)

I hereby authorize and request you to release:

- Medical records in your possession concerning my illness and/or treatment including pathology reports, scans, physician notes, chemotherapy treatment, laboratory tests, operative reports, and any other pertinent information during the period from _____ to _____. (If no dates are indicated, then please provide the last two years of data)
- Only the medical records indicated: _____
- In addition, I authorize release of sensitive health information, including information regarding HIV/AIDS, psychiatric, drug/alcohol abuse, genetic testing, STDs

Release **From:** _____
Name

Address City State Zip

Phone Fax

Release **To:** **San Diego Pacific Oncology & Hematology Associates, Inc.**

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ENCINITAS
477 N. El Camino Real
Ste D200
Encinitas, CA 92024
Tel. 760.452.3340
Fax 760.452.3344 | <input type="checkbox"/> Alberto Bessudo, MD
<input type="checkbox"/> Laurie Frakes, MD
<input type="checkbox"/> Edward McClay, MD | <input type="checkbox"/> LA JOLLA
9850 Genesee Ave.
Ste 830
La Jolla, CA 92037
Tel 858.552.1410
Fax 858.552.0929 | <input type="checkbox"/> Pushpendu Banerjee, MD.
<input type="checkbox"/> James Sinclair, MD |
| <input type="checkbox"/> ESCONDIDO/POWAY
625 W. Citracado Pkwy
Ste 110
Escondido, CA 92025
Tel. 760.747.8935
Fax. 760.747.7951 | <input type="checkbox"/> Steven Eisenberg, DO
<input type="checkbox"/> Richard Just, MD
<input type="checkbox"/> Edward McClay, MD | <input type="checkbox"/> VISTA
161 Thunder Drive
Ste 106
Vista, CA 92083
Tel. 760.208.6730
Fax 760.208.6736ana | <input type="checkbox"/> Alberto Bessudo, MD
<input type="checkbox"/> Laurie Frakes, MD
<input type="checkbox"/> Edward McClay, MD |

This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken. I understand that I have the right to receive a copy of this authorization upon my request. I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained from me.

Patient or Guardian Signature Relationship to Patient Date: _____

NOTE CONCERNING PROTECTED HEALTH INFORMATION

This information is strictly confidential and is needed for the purpose of treatment and or billing purposes. San Diego Pacific Oncology will accept no responsibility if it is made available to any other person, including the patient. For certain patient records, state and federal laws protect confidentiality. These laws prohibit you from making any further disclosure without the specific written authorization of the person to whom the information pertains or as otherwise permitted by regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.

IF YOU RECEIVE THIS FAX IN ERROR

If you are not the intended recipient or the person responsible for delivering this material to the intended recipient, you are hereby notified that any dissemination or copying of this material is strictly prohibited.

A photocopy of this form may be deemed as valid