Request for Transfer of Records

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As required by the Health Information Portability and Accountability Of 1996 and California law, you have the right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another healthcare provider.

Patient Name:_____Date of Birth_____

Address:_____

Phone number:_____

Type of records requested and charges:

___All records (minimum charge $25; over 60 pages $40)

___Basic records (no charge)-copy of immunization record, growth chart(s) & last physical exam only.

Transfer records to:

Name:_____

Address:_____

City, State & ZiP:_____

___ I hereby agree to pay the charges

___Please call me to let me know how much these copies will cost

PLEASE NOTE: FEES MUST BE PAID WHEN SUBMITTING REQUEST FORM

Signature of Parent or Guardian:_____Date:_____

Print name:_____Telephone:_____