SAN DIEGO ARTHRITIS MEDICAL CLINIC
Michael I. Keller, M.D., Inc.

Authorization to Release Protected Health Information

(HIPAA Compliant Request for Information/Medical Records)

Patient's Full Name _____ Date of Birth _____

Patient's Address _____ Telephone Number _____

Name of Medical Office/Company/Entity You Want to Send Records _____

Street Address _____

City, State, Zip Code _____

Type of Information:

❒ Pertinent Records of the Past Three Years of Treatment

❒ All Medical Records (I understand this requires approval from the privacy officer and may take up to 30 days)

❒ Specific Records as Detailed Below:

❒ Office Notes ❒ Consultation Reports ❒ Lab Reports ❒ NCV Reports

❒ X-Ray Reports ❒ Bone Density Reports ❒ Billing Reports ❒ Other _____

Dates of Service: From ____/____/____ To ____/____/____

Purpose: ❒ Patient Request ❒ Continuing Medical Care ❒ Attorney Request ❒ Other _____

I understand that my health record may include information relating to Sexually Transmitted Diseases; Acquired Immunodeficiency; (AIDS); Human Immunodeficiency Virus (HIV), and other communicable diseases. Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes the release of such information. I may refuse to sign this authorization and I understand that San Diego Arthritis Medical Clinic will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time in writing, except to the extent that action has been taken based on this authorization. Unless otherwise revoked this authorization is valid from one year.

I understand that once my information is released, San Diego Arthritis Medical Clinic will no longer be able to protect that information. I release San Diego Arthritis Medical Clinic and its employees from any legal liability that may arise from the disclosure of the above information.

I understand there is an administrative fee associated with the duplication of my records. Please allow 7-10 days for any duplication of records.

Legally Authorized Representative (Print) _____ Date _____

Legally Authorized Signature _____ Relationship to Patient _____

PLEASE SEND MY RECORDS TO:

❒ San Diego (Main Office)
3633 Camino Del Rio South
Suite 300
San Diego, California 92108
Tel: 619-287-9730
Fax: 619-287-4516

❒ Chula Vista
1310 Third Avenue
Suite B3
Chula Vista, California 91911
Tel: 619-827-0276
Fax: 619-827-0297

❒ Poway
15725 Pomerado Road
Suite 108
Poway, California 92064
Tel: 858-376-0203
Fax: 858-376-0210

❒ El Centro
441 W. State Street
El Centro, California 92243
Tel: 760-337-2949
Fax: 760-337-5698

❒ Yuma
2475 S. Avenue A
Suite A
Yuma, Arizona 85364
Tel: 928-314-0099
Fax: 928-314-1590