Central Coast Renal Care

Medical Records Request/Release

Date of Request: _____
mm/dd/yy

Patient: _____
Last First DOB (mm/dd/yy)

Requesting Party (if different than patient): _____
Last First DOB (mm/dd/yy)

Relationship to Patient: Parent/Guardian Spouse Attorney Other: _____
Please Specify

I am requesting a copy of my, or a patient which I represent, medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations. I, or the patient I represent, was treated in your office, Central Coast Renal Care, between the dates of:

_____ through _____ or ☐ I am unsure of the dates I, or the person I represent, attended
mm/dd/yy mm/dd/yy

I wish to receive copies of the following health records related to my treatment:

☐ All Records

☐ Most Recent Visit Note

☐ Radiology Reports for Services Requested by my Provider

☐ Other: _____

***** PLEASE NOTE: Medical Billing Records Requests can be directed to Werking Medical Billing at (805) 571-1100*****

Under HIPAA Section 164.524, I can be charged a reasonable fee for copying records. I may also be charged for postage if I ask that records be mailed to me. HIPAA allows 30 days for a provider to respond to my request for records, with one 30-day extension for good reason. In accordance with California Health & Safety Code Section 123100, a record preparation fee of $4 plus $0.25/page will be charged. Government issued photo ID will be required of the individual picking up records.

Please specify how you wish to receive your records:

☐ I wish to pick up my records in person

☐ I wish to release my records to:

☐ Alternate Party: _____

☐ I wish to have my records faxed to:

☐ Central Coast Renal Care at (805) 548-8589

☐ Other: _____

Requesting Party: _____ Date (of Pickup) _____
(Signature)

Total Pages Printed (X ¢0.25 each): $_____
Preparation Fee: $ 4.00
Postage: $_____
Total Fee Due: $_____