perlmanclinic++

Perlman Clinic Medical Records Transfer Request

Attn: Medical Records Department
3900 5th Avenue Suite 300, San Diego, CA 92103
medicalrecords@perlmanclinic.com
(P): 858.554.1212
(F): 858.795.1195

Date of Birth:	Patient's Legal Name: Last First Middle	Patient's Phone Number:

I request a copy of the following medical records*** (the "Medical Records") be:
(**ONLY CHOOSE ONE)**

☐ **Delivered to** Perlman Clinic by the below listed Facility/Person

☐ **Provided by** Perlman Clinic to the below listed Facility/Person

☐ **Transferred through Email** by Perlman Clinic to the below listed Facility/Person: The delivery of Medical Records by use of email is not secure for HIPAA protected information. Nevertheless, I am instructing Perlman Clinic to email my Medical Records to the following email, and I assume all risks thereof and agree to hold Perlman Clinic harmless: _____Initials

***Note: We can only release Perlman Clinic records. If you have sent us outside records, we cannot release these to other facilities. You will need to request the release of those records directly from the original facility.

☐ **Without Limitation:** Complete medical records shall be provided, including without limitation, Biopsy Report(s) and Laboratory Report(s).

☐ **Limited to the following:** (Please check)

☐ Discharge Summary ☐ History/Physical ☐ Consultation Reports ☐ Progress Notes ☐ Lab Tests
☐ X-Ray/Imaging Reports ☐ Billing Records ☐ Pharmacy Records ☐ Other:_____

***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Facility/Person:	Phone Number:	Fax Number:

Address:
Street City State Zip

Email Address:

I release Perlman Clinic and the Facility/Person from any claim and liability that may arise from the release of the Medical Records. I further understand that this Authorization is voluntary and that I may refuse to sign this Authorization. My refusal to sign will not affect my ability to obtain treatment; or receive payment or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. Upon written request, you may request a copy of this Authorization and/or revoke this Authorization (except to the extent that action has been taken in reliance thereon).

Signature of Patient or Parent/Guardian/ Healthcare Power of Attorney/Executor	**Printed Name** of Patient or Patient Representative	**Date** – This Authorization will expire one (1) year from the above date.