Eric S. Lee, M.D

Pacific Bay Dermatology
Dermatology & Cutaneous Surgery

Authorization to Release Copies of a Medical Record

(must be hand written)

Patient Name:_____ Date of Birth:_____

____ **Myself:** I request Dr. Eric Lee, M.D. to release my information to myself.
Selected delivery method: ____Pick-up ____Mail ____Fax (____)_____
____ **Other:** I request Dr. Eric Lee, M.D. to release my information to:
Individual/Organization:_____
Address:_____
City/State:_____ Zip_____ Telephone (____)_____
Selected delivery method: ____Mail ____Fax (____)_____
Purpose of release to other individual/organization:
____Transfer of Care
____Attorney/Legal
____Insurance Company ____Workman's Compensation
____Other:_____

Requested Records:
____ office visit notes ____ pathology reports
____ other:_____

Fees are authorized by the State of California Code Section 1560-1567
____Last three years $15.00
____Over three years $25.00
____Over five years $35.00

I understand and agree to pay the fee associated with the record request. Records will be copied and sent within 10 to 14 business days. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Please indicate if records are needed sooner.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Printed Name of Legally Authorized Representative
Relationship to Patient: ____ Spouse ____ Parent ____ Other:_____

284 Foam Street, Ste 28, Monterey CA 93940Phone (831) 372-3228 Fax (831) 372-2328
15215 National Ave, Ste 204, Los Gatos, CA 95032Phone (408) 848-0888 Fax (408) 848-0999