SKIN CARE AND LASER
PHYSICIANS OF BEVERLY HILLS
GENERAL AND COSMETIC DERMATOLOGY

Authorization to Transfer Medical Records

I hereby authorize ______________________________ to furnish
Physician Name / Medical Clinic

medical information concerning ______________________________
Patient Last Name, First Name and Date of Birth

to the following entity **via mail or fax:**

____
Name

____
Street, Apartment

____
City, State, Zip Code

______________________________ ______________________________
Phone # Fax#

Any and all information may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and alcohol abuse records, and HIV test results, if any, except as specifically provided below:

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I understand and agree to pay a reasonable charge to cover the cost of the transfer. I understand the costs will be computed based on a copying fee of 25 cents per page for standard documents, actual costs for the reproduction of oversized documents or documents requiring special processing, and reasonable clerical costs for locating and making the records available.

This authorization is effective now and will remain effective until otherwise revoked.

I understand that I may receive a copy of this authorization.

______________________________ ______________
Signature Date

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient
- ☐ Other______________________________