ASI | American Skin Institute

Dermatology | Cosmetic Surgery | Mohs Skin Cancer Surgery & Reconstruction

Patient Request for Health Information

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth (MM/DD/YYYY):_____ Last 4 digits of SSN: _____

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ___/___/___ through ___/___/___ Office Visit Chart Notes ☐ Pathology Reports ☐
Operative/Procedure Reports ☐ HIV Tests ☐

Other Records ☐ Please specify: _____

How would you like your records delivered?

Paper: Home Delivery ☐ Paper: In-Person Pickup ☐ Electronic ☐ Please specify: _____

Records Requested From

☐ **American Skin Intitute (ASI)**
4836 Van Nuys Blvd. Sherman Oaks, CA 91403
Tel: 818-907-SKIN (7546) Fax: 818-907-9506

☐ **Other** _____
_____
_____

Recipient of Records

☐ **Other** _____
_____
_____

☐ **American Skin Intitute (ASI)**
4836 Van Nuys Blvd. Sherman Oaks, CA 91403
Tel: 818-907-SKIN (7546) Fax: 818-907-9506

Recipient Relationship: Patient (self) ☐ Physician ☐ Patient Representative Recipient Email (if applicable): _____

Please print your name and sign below:

Name of Patient or Personal Representative: _____ Relationship: _____

Signature of Patient or Personal Representative:: _____ Date / Time: _____

Please return completed form to:

American Skin Institute
4836 Van Nuys Blvd.
Sherman Oaks, CA 91403

Email: Info@AmSkin.com
Fax: (818) 907-9506
Questions?: _____

NOTICE

American Skin Institute and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

- *I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create pHI to provide to a third party.*
- *I may revoke this authorization at any time, provided that I do so in writing and submit it to American Skin Institute at 4836 Van Nuys Boulevard, Sherman Oaks, CA 91403. The revocation will take effect when American Skin Institute receives it, except to the extent that American Skin Institute or others have already relied on it.*
- *I am entitled to receive a copy of this Authorization.*

EXPIRATION OF AUTHORIZATION _____

Unless otheruyise revoked, this Authorization expires (insert applicable date or event). If no date is indicated, this Authorization will expie 12 months after the date of signing this form.

SIGNATURE _____

American Skin Institute recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.