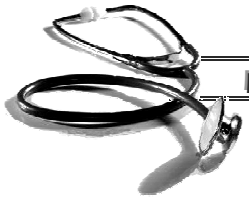


LOS ANGELES SPECIAL CARE MEDICAL ASSOCIATES
Hollywood Office
1300 N VERMONT, STE.805 DOCTORS TOWER,L.A., CA 90027
(PH)323-953-2956 (FAX)323-913-2588

FORM: "AUTHORIZATION TO RELEASE MEDICAL RECORDS"

PURPOSE : FOR PUPOSES RELATED TO THE TRANSITION OF CARE FROM ONE PROVIDER TO ANOTHER OR THE ACQUISITION OF IMPORTANT MEDICAL INFORMATION BY A NEW PROVIDER INVOLVED IN YOUR CARE, THIS FORM AUTHORIZES OTHER PROVIDERS TO RELEASE ALL OR SPECIFIC MEDICAL INFORMATION IN YOUR CHART TO LASCMA-HOLLYWOOD.

OTHER INFORMATION: FOR THOSE WHO HAVE EXTENSIVE PRIOR MEDICAL HISTORIES, COPIES OF ONE'S MEDICAL INFORMATION MAY PROVE VITAL IN THE MANAGEMENT OF CARE BY ANY NEW PROVIDER. DO KEEP IN MIND THAT MOST PRIVATE PRACTICES AND SOME CLINICS AND HOSPITALS DO REQUIRE A CHARGE FOR COPYING AND MAILING YOUR MEDICAL INFORMATION. THE USUAL AND CUSTOMARY CHARGE IN THE LOS ANGELES AREA FOR SUCH A REQUEST SUCH RANGES FROM $15 UP TO $45. THE COST, WHICH IS LARGELY DEMOGRAPHICALLY DRIVEN, IS ALSO FREQUENTLY DEPENDENT ON THE VOLUME OF THE CHART AND PHILOSPHY OF THE PRACTICE. THUS, WE RECOMMEND THAT YOU INQUIRE YOURSELF ABOUT THE COSTS INVOLVED (IF ANY) AS WELL AS THE STATUS OF YOUR REQUEST ONCE IT HAS BEEN RECEIVED.

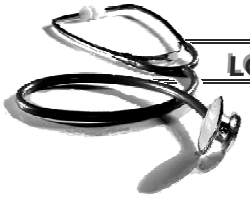
INSTRUCTIONS:

1- **READ AND COMPLETE THE FOLLOWING PAGE WHICH CONSISTS OF THE ENTIRE FORMAL REQUEST THAT ONE'S MEDICAL RECORDS (OR A SPECIFIED PORTION THERE-OF) BE COPIED AND MAILED TO LASCMA-HOLLYWOOD. YOU MAY COMPLETE THE NECESSARY INFORMATION BY HAND OR DIRECTLY WITH ADOBE ACROBAT READER (VERSION 5 OR GREATER).**

2- **PRINT A COPY OF THE FORM AND BE SURE TO SIGN IT.**

3- **MAIL OR FAX THE COMPLETED (+ SIGNED) FORM TO THE PROVIDER WHOM INFORMATION IS REQUESTED. AGAIN, WE STRONGLY RECOMMEND THAT YOU FOLLOW UP ON THE STATUS OF YOUR REQUEST IN ABOUT 2 WEEKS FROM THE DATE THE FORM WAS SENT.**

4- **ONCE AGAIN, PLEASE BE AWARE THAT THERE MAY BE A CHARGE FOR A REQUEST TO COPY YOUR MEDICAL INFORMATION. ADDITIONALLY, NEITHER LASCMA NOR (IN MOST CIRCUMSTANCE) YOUR HEALTHPLAN WILL ASSUME RESPONSIBLE FOR PAYMENT OF ANY SUBMITTED CHARGES. FOR MORE INFORMATION, PLEASE CALL THE PROVIDER'S OFFICE DIRECTLY AND ASK ABOUT HIS/HER POLICY ON COPYING AND MAILING ONE'S MEDICAL RECORDS.**



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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION
(first & last name of client)

RECORDED AT _____, LOCATED AT _____
(name of provider, office, clinic or hospital) *(address of provider, office, clinic or hospital)*

TO **LASCMA-HOLLYWOOD, ATTN: MED RECORDS,1300 N VERMONT, STE#805 DOCTORS TOWER, LOS ANGELES, CA 90027**.

PLEASE COPY AND SEND ONLY THE FOLLOWING INFORMATION FROM MY RECORDS AS INDICATED BELOW:

- ☐ **MY ENTIRE CHART OR RECORDED INFORMATION.**
- ☐ **ONLY THE INFORMATION PERTAINING TO PPD STATUS, VACCINATIONS AND INJECTABLES GIVEN (& CORRESPONDING DATES) AS FOUND IN MY RECORDS.**
- ☐ **ONLY THE LABORATORY & RADIOGRAPHIC DATA FOUND IN MY RECORDS.**
- ☐ **ONLY THE LABORATORY AND RADIOGRAPHIC DATA FROM _____ TO THE MOST RECENT DATE ON FILE IN MY RECORDS.**
- ☐ **ONLY THE SPECIFIC INFORMATION AS NOTED BELOW (WITH CORRESPONDING DATES, AS APPROPRIATE):**

  _____
  _____
  _____
  _____

I REALIZE I MAY BE RESPONSIBLE FOR ANY REASONABLE COSTS INVOLVED IN COPYING AND MAILING MY MEDICAL INFORMATION TO THE ABOVE NOTED MEDICAL PROVIDER. IF THERE IS A CHARGE FOR SUCH A REQUEST, PLEASE:

- ☐ **COPY & MAIL MY RECORDS AS REQUESTED AND BILL ME.**
- ☐ **INFORM ME OF ANY CHARGES FOR I MAY BE RESPONSIBLE BEFORE CARRYING OUT THIS REQUEST.**

_____ _____
(name of client) *(current address of client)*

_____ _____
(signature of client) *(current phone number of client)*

_____
(date of client's request & signature)