



Email: Medicalrecords@skinusa.com

Medical Records fax only # 661.425.0425

California Medical Records Release Authorization

Patient Name: _____ DOB: _____

Phone Number: _____ Date: _____

You can view and download your medical records for free on the patient portal. **If you prefer to have them emailed, picked up in office or mailed please allow up to 15 days to receive Medical Records.**

How would you like to receive your medical records? Please check option(s) below and fill in the information if needed

☐ **Pick Up in Office or Mail Paper Copies (Self)**

☐ California Processing fee **\$6.50 + \$0.25 per page**

If you prefer to pick up your medical records in the office, please write 'Office Pick Up' in the mailing address line below

Mailing Address is applicable: _____

Please check the appropriate box(es) below.

☐ **Email Medical Records to Patient (Self)**

☐ **Sending to Another Provider or third party.**

☐ **California: \$6.50 flat fee (applies to records released to you or sent directly to another provider or third party at your request).**

Provider / Facility Name: _____

Fax: _____

Email: _____

☐ **All Records:**

Specific Dates of Services: _____ to _____

Specific Request: _____

By signing below, I acknowledge that I have been informed of the free digital access available through the Patient Portal. If I have selected an option that requires a fee, I agree to pay the associated processing fees.

Patient/Guardian Signature: _____ Date: _____