TAMJIDI
SKIN
INSTITUTE

Authorization for the
Release of Protected Health Information

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As allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations, the purpose of this letter is to ask for copies of my medical records.

Patient name: _____ Date of birth: _____ Telephone #: _____

(Check **ONE** option) □ Tamjidi Skin Institute to send my records to:
□ Tamjidi Skin Institute to obtain my records from:

Name of the medical office or authorized party: _____

Complete Street Address: _____

Telephone number: _____ Fax number: _____

I need my entire records OR specific records: _____

I look forward to the requested party receiving the above records within 30 days as specified under the HIPAA. Please inform me if my request cannot be honored within the 30 days with the expected arrival date of my records.
I understand there may or may not be a cost associated with the request of my records. If any, I ask that you please bill me with the cost of providing copies of my medical records.

_____ _____ _____
Patient Printed Name Patient Signature Date

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