SALL RESEARCH MEDICAL CENTER
REQUEST FOR TRANSFER OF HEALTH INFORMAITON

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the transfer of health information described below. Please review and complete this form carefully. It may be invalid if not fully completed.

I HEREBY REQUEST THE TRANSFER OF HEALTH INFORMAITON:

_____

Patient's Name Date of Birth

_____

Address City, State Zip Code

PLEASE TRANSFER OR RELEASE A COPY OF MY MEDICAL RECORDS TO:

_____

_____

_____

_____

(Name, phone number, fax number and address of health care provider to whom the records are to be transferred to)

I HEREBY AUTORIZE THE TRANSFER OF MY MEDICAL RECORDS

_____ _____

Signature Date

Please mail form to 11432 South Street #227 Cerritos, CA 90703 or fax to 562-804-4350