Medical Information and Records Request Packet

Hello and thank you for your interest in our practice. Please read this page carefully and follow the instructions. Your cooperation is greatly appreciated and will help insure you get an appointment in a timely manner.

Dr. Diane Dickinson requires a copy of your medical records prior to your scheduling an appointment.

Your records must be received and reviewed by our office before you are able to schedule an appointment. Please use the Medical Records Request form in this mailing to order a copy of your records.

Fill out the ***Request for Medical Records*** form and send it to your physician's office. They will send a copy of your records to our office.

We will call you to schedule an appointment when your medical records arrive in our office.

Appointment Cost:

The fee for an appointment is $150 (money order only). Please wait until we call you with an appointment before sending your payment in**.**

Appointment Location:

We see patients in several locations. Please be sure to specify in which office you wish to be seen when we call to schedule your appointment.

Appointments are 20 minutes in length. We ask you to please be on time, and call 48 hours in advance should you need to cancel.

Thank you for making this an efficient and affordable process.

REQUEST FOR MEDICAL RECORDS

PATIENTS PLEASE: MAKE NECESSARY COPIES & SEND TO ALL HEALTH CARE PROVIDERS

The undersigned (or patient's legal representative) hereby authorizes release of requested medical records to Dr.Diane Dickinson. I understand that I am responsible for any fees related to this request, that I have a right to access my records, and that I may rescind this authorization at any time.

Print Patient Name _____

Patient Signature _____

Date of Birth _____ **SS#** _____

Today's Date _____ **Date Authorization expires** _____

Phone: Daytime _____ **Evening** _____

Requesting Records From:

Send Records To:
North Coast Medical
P.O. Box 1127
Arcata, CA 95518
707-826-1165

Medical Record #, if known (for hospitals or Kaiser) _____

Purpose of request: update consulting physician, other_____

***** Please Do Not Send Any Lab Results *****

Send ALL records _____

Send only records from _____ to _____

HOSPITAL RECORDS: Send only discharge summaries

RELEASE INCLUDES DISCLOSURE OF (INITIAL LINES BELOW):

Psychiatric records _____

Substance Abuse _____

HIV/STD/ _____

DO NOT SEND ANY X-RAYS

Diane Dickinson, MD
P.O. Box 1127, Arcata, CA 95518
707-826-1165
CML:G69727