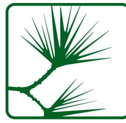

CITY OF DEL MAR

DATE: __________

PATIENT NAME: ____________________________
INCIDENT NUMBER: ____________________________
DATE OF SERVICE: ____________________________

We have received your recent inquiry regarding a request for medical records. The information below will allow us to legally expedite your request.

According to established legal requirements, as custodians of protected health information, we are not able to release any record without a signed written authorization from the patient or their legal representative. To facilitate this process, please sign and return this letter confirming that you authorize a copy of the above medical record(s) for release. Also include a copy of your driver's license or state identification.

If you are the patient's Conservator, Medical Power of Attorney, or Executor, please provide a copy of the legal documentation appointing you. You must also include a copy of the patient's death certificate and a copy of your driver's license or state identification so we can expedite your request. The records will then be mailed to the patients address only, unless noted otherwise by your legal documentation.

We will be glad to process your request upon receipt of this signed release accompanied by the required information listed above. If you have any further questions or concerns, please contact Sarah Krietor in the Administrative Services Department at (858) 755-9313 x1154 or cityclerk@delmar.ca.us. Signed forms can be dropped off at City Hall, 1050 Camino del Mar, Del Mar CA, 92014.

Patient Signature: __________________________ Date: ______________________

Patient Printed Name: ______________________ Date: ______________________

Requestor Information

Requestor Printed Name (If other than patient): _____________________________

Requestor Signature: ____

Relationship to Patient: ____

Driver's License Number: ____

Please Remit To: CITY OF DEL MAR
ADMINISTRATIVE SERVICES DEPARTMENT
cityclerk@delmar.ca.us