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AUTHORIZATION FOR RELEASE MEDICAL INFORMATION

This authorization to release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act (California Civil Code, Section 56, et. Seq.). The purpose of this request is to make available medical information to continue care for:

Please Print:

Name of Patient

Date of Birth

Telephone Number

I authorize the release of any discussion relating to all medical information, including Initial History, Physical and Progress notes for the last seven (7) years and the following:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Correspondence | <input type="checkbox"/> Lab/EKG |
| <input type="checkbox"/> Pulmonary Function Tests (PFT sheet) | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Allergy Injection record (immunotherapy)
1 st and last page | <input type="checkbox"/> Other _____ |

Records Requested From:

Send Records To:

Name of Physician/Clinic

Name of Physician/Clinic

Address

Address

City, State, Zip Code

City, State, Zip Code

Telephone Number

Telephone Number

This authorization shall be effective on _____ and shall remain in effect indefinitely.

Signature of Patient/Parent or legal guardian

Date

We are allowed 14 days from date of request to copy records.

There will be a \$15.00 charge for medical records to self, immediate request, or patient pickup.