3000 Colby Street, Suite 203B, Berkeley, CA 94705. P: (510) 883-9005, F: (510) 883-9006

Release of Medical Information

I, ________________________________,with a date of birth,____________________, give my permission
(patient's name) (Patient DOB)

__________________________________to give my medical records to ______________________________
(doctor's or hospital name who has records) (My doctor's name)

so that he/she can better understand my condition and help me.

I agree to transfer (please choose one)

☐ All medical records

☐ only the following parts of the medical records (specify):

____

Patient's Signature____ Date _______________

Authorized Representative's Signature________________________ Date________________

Relationship of Authorized Representative____

Consent for release of medical records for ____
(Patient name)

Date: ____________________________________

Office sending records :

Name of Practice: ___________________________________

Name of Physician:___________________________________

Fax number: ____

Address: ____

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office receiving records:

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