Sana Medical Group, INC.

Jose Villagomez, M.D.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME (NOMBRE DEL PACIENTE) _____ **BIRTH DATE** (FECHA DE NACIMIENTO) _____

ADDRESS (DOMICILIO) _____ **CITY** (CIUDAD) _____ **STATE** (ESTADO) _____ **ZIP CODE** (ZONA POSTAL) _____

RELEASE FROM:
NAME OF THE PHYSICIAN/CLINIC
NOMBRE DEL DOCTOR O CLINICA

_____
ADDRESS (DOMICILIO)

_____
CITY/STATE/ZIP CODE (CIUDAD/ESTADO/ZONA POSTAL)

_____/_____
TELEPHONE (TELEFONO)/ **FAX NUMBER**

RELEASE TO:

SANA MEDICAL GROUP, INC.

12099 W.WASHINGTON BLVD. #400
LOS ANGELES, CA 90066
TEL. 310-398-3803 FAX. 310-398-5189

I HEREBY AUTHORIZE AND REQUEST THAT THE ABOVE NAME PHYSICIAN OR HEALTH CARE GROUP TO RELEASE INFORMATION CONCERNING MY HEALTH TO MY PHYSICIAN OR MEDICAL GROUP.
Yo autorizo, y requiero que se mande al doctor o grupo medico mencionado arriba toda la informacion acerca de mi historia medica o todo tipo de examenes, como laboratorios, rayos x, e informacion clinica

☐**FAX REPORT** ☐**MAIL REPORT**

☐**ENTIRE CHART FROM_____ TO_____** ☐**CLINIC NOTES**

☐**HISTORY & PHYSICAL EXAM** **Dated on_____/_____/_____** ☐**IMMUNIZATION RECORD**

☐**LABORATORY** **Dated on_____/_____/_____**

☐**X-RAYS REPORT** **Dated on_____/_____/_____** **FOR: _____**

☐**EKG REPORT** **Dated on_____/_____/_____**

☐**OTHER:_____**

_____ **DATE: _____**
PATIENT SIGNATURE (Firma del paciente)

_____ _____ **DATE: _____**
SIGNATURE OF PARENT OR GUARDIAN **Relationship**
(Firma de los padres o del tutor) Relacion