Patient's Authorization to Release Medical Records

(Complete the information below for each previously treating doctor and/or hospital. Submit the completed form to your doctor's medical records office.)

Date	Patient's Social Security #		Medical Record # (Office Use Only)	
Patient's Last Name		Patient's First Name		
Patient's Address	Street Name			Apt #
	City		State	Zip Code
Date of Birth	Home Phone ( )	Cell Phone ( )	Fax # ( )	

I ________________________________(print patient's name) request the release of my medical records **from**

Name of Facility / Hospital	Street Address		Suite #
	City	State	Zip Code
Name of Doctor/Provider			
Fax Number ( )	Phone Number ( )		

☐ **to** be faxed or mailed to me at my fax number or address above.

☐ **to** my evaluating provider in accordance with the Health Insurance Portability and Accountability Act (HIPAA):

Monrovia Internal Medicine and Primary Care
P.O. Box 2063
Monrovia, CA 91017
Phone / Fax #: (877)254-4496

I was treated in your office between [dates]_______________and _____________ I request copies of the following [or all] health records related to my treatment(s).

☐All Records ☐ Labs ☐Discharge Summary ☐Medication List ☐Imaging Studies ☐Progress Notes Only

Please include a copy of photo identification if it is available on file or a copy of a State Issued ID Card or Passport to confirm my identification. Thank you for your cooperation.

Patient's Signature____ Date_____/______/______