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Authorization to Release Medical Records

I HEREBY AUTHORIZE DISCLOSURE OF MEDICAL INFORMATION OBTAINED DURING THE COURSE OF MY EVALUATION AND/OR TREATMENT.

Patient's Name: _____

Date of Birth: _____ Social Security Number: ____ - ____ - ____

Signature: _____ Date: _____

I authorize:

Physician or Medical Group

Street Address

City

State

Zip Code

Phone

Fax

To release my health information to:

Heidi Freeman, M.D.
1035 Peach St., #301
San Luis Obispo, CA 93401

To include:

<input type="checkbox"/> All Medical Records	<input type="checkbox"/> Mammogram Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> History and Physicals	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> All Pap Smears
<input type="checkbox"/> Ultrasound Reports	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Other:
