161 Thunder Drive, Vista CA 92083
Phone: (760) 758-1988 Fax: (760) 758-0922

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize: _____

_____

(Name of Facility, Address, Phone Number, Fax Number)

To furnish medical records to the office of Dr. Hurd/ Dr. Patel. These records are needed for the purpose of continuity of care.
Please fax us the records back. Thank you!

Please provide records from: _____ **to** _____
(Date) (Date)

I understand the General Records may contain:

- **Emergency Room Reports/ Admission & Discharge Reports**
- **Doctor's Office Notes**
- **Imaging/ radiology, procedures and cardiac tests**
- **Lab/ pathology reports**
- **Medical and/or Mental or Emotional Conditions**
- **Alcohol and Drug Conditions**
- **HIV Testing results**
- **Other Sensitive Information**
- **Other (something specific only)**_____

I understand I may formally request exclusion of any sensitive information and I wish to exclude:_____

The patient has a right to have a copy of this authorization. This consent shall remain valid for one year from the date of the signature.

Patient Name: _____ **Date of birth:**_____

Address: _____

Signature:_____
(Please circle: Patient/ Parent/ Guardian/ Legal Rep./ PCP office Rep)

Date:_____ **Expires:**_____ **(one year after date)**