AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Release records from: _____
(Name of doctor, clinic, hospital)
Address: _____

Phone and Fax No.: _____

I, _____, request that my medical records be released to:
(Patient's name and Date of Birth)

Dr. Warren Klausner
129 Jewell Street
Santa Cruz, CA 95060
PH: 831. 420. 1400
Fax: 831. 420. 1401

Please release the following information:

- ❒ X-rays, MRI, CT Reports
- ❒ Lab results
- ❒ Complete medical record

I understand that I have a right to receive a copy of this authorization upon my request.

Copy requested? ❒ Yes ❒ No

Signature: _____ Date: _____

Signed by: ❒ Patient ❒ Spouse ❒ Parent ❒ Guardian