AUTHORIZATION TO RELEASE MEDICAL INFORMATION

RELEASE RECORDS FROM: Dr. Warren Klausner
129 Jewell Street Santa Cruz CA 95060
Phone: 831 420-1400 Fax: 831 420-1401

I, _____, request my medical records be released to:
(Patient name and date of birth)

Name: _____
Address: _____
Fax Number: _____ Phone Number: _____

PLEASE INCLUDE:

___ LAB RESULTS

___ X-RAY, MRI, CT REPORTS

___ COMPLETE MEDICAL RECORDS

___ INJURY RECORDS

___ ILLNESS RECORDS

For the purpose of _____ (please specify:

review, investigation, claim processing, application evaluation or any other purpose)

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

Copy requested? ___ Yes ___ No

SIGNATURE: _____ **DATE**: _____

Signed by: ___ Patient ___ Spouse ___ Parent ___ Guardian