AUTHORIZATION TO RELEASE MEDICAL INFORMATION FROM DR KLAUSNER

Release records from: Dr. Warren Klausner
129 Jewell Street
Santa Cruz, CA 95060
831.420.1400
831.420.1401(Fax)

I, _____ _____ request that my medical records be released to:
Patient's Name Date of Birth

Name of doctor, clinic, hospital _____

Address _____

Phone _____ Fax _____

Please release the following information:

- ☐ X-rays, MRI, CT Reports
- ☐ Lab results
- ☐ Complete medical record
- ☐ Injury records
- ☐ Illness records

For the purpose of _____
(please specify: review, investigation, claim processing, application evaluation or any other purposes)

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

Copy requested? Yes ☐ No ☐

Patient signature _____ Date _____

Signed by ☐ Patient ☐ Spouse ☐ Parent ☐ Guardian