Family Medicine Center
of Torrance

MEDICAL RECORDS RELEASE AUTHORIZATION

*****I HEREBY REQUEST THAT MY RECORDS BE RELEASED FROM:**

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*****I HEREBY REQUEST THAT MY RECORDS BE RELEASED TO:**

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CONCERNING MY ILLNESS AND /OR TREATMENT DURING THE PERIOD

FROM_______________________THROUGH__________________________

I UNDERSTAND THAT THIS AUTHORIZATION MUST BE FILLED OUT COMPLETELY AND SIGNED IN ORDER TO BE CONSIDERED VALID. A COPY OR FAX THAT HAS NOT BEEN ALTERED WILL BE CONSIDERED AS VALID AS AN ORIGINAL.

PLEASE PRINT AND FILL OUT COMPLETELY:

*****NAME:__________________________________MAIDEN NAME:_____________________________**

DATE OF BIRTH_______________ADRESS____

SIGNATURE____DATE________________________________

(IF RELATIVE OR MINOR, STATE RELATIONSHIP):

WITNESS____

THIS AUTHORIZATION WILL BECOME PART OF YOUR PERMANENT MEDICAL RECORD AND WILL EXPIRE 18 MONTHS FROM THE DATE SIGNED. THIS AUTHORIZATION IS SPECIFIC FOR THE STATED PHYSICIAN, CLINIC OR HOSPITAL ONLY.