Authorization to Transfer Medical Records

I hereby authorize:____

To furnish medical information concerning the patient:

Name:____**DOB**:______________

Phone:___________________________**Email**:______________________________

To:_____________________________________
____
____
____

Please include the following:

( ) All records including lab test and pathology reports.

( ) Other:____

I understand that I may receive a copy of this authorization.

Signed____

( ) Parent or Guardian of minor patient.

( ) Guardian or Conservator of patient.

( ) Beneficiary or personal representative of deceased patient.

Confidentiality Notice:
The documents accompanying the telecopy transmission contain confidential information belonging to the sender, which is legally privileged. The information is intended only for the use of the individual or entity above. If you are not the intended recipient, you are hereby notified that any disclosure, copy, distribution or the taking of any action reliance on the contents of this telecopy information other than for the expressed intent is strictly prohibited. If you have received this in error, please notify us by telephone at (831) 373-4404 to arrange for the return of the original documents to us.