

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: (Provider) _____
(NAME OF DOCTOR, CLINIC, HOSPITAL, ETC.)

Address: _____

I, _____ request the following information:
(PATIENT'S NAME)

- X-rays History Records Diagnosis Treatment Reports Billings
concerning my: Accident Injury Illness Other _____

To be released to: Myself the Patient or sent to Dr. Robert S. Renfro
(NAME OF INSURANCE CO., ATTORNEY, DOCTOR, HOSPITAL, EMPLOYER)

Address 206 N. Euclid St., Fullerton, CA. 92832 - 714-526-9355 tel or 714-526-9350 fax

For the purpose of: Review
(SPECIFY)

According to Section 25252 of the California Health and Safety Code, these records must be provided within 15 days of receipt of this notice.

Signed: _____ Date: _____

- Patient Spouse Parent Guardian

