Authorization For Release of Medical Records

Karen Goodrich, M.D.
1428 Phillips Lane, Suite 201
San Luis Obispo, CA 93401
805.548.8545 phone
805.548.8548 fax

I, ________________________ authorize release of my medical records from:
Dr.:____
Address: ____
City, State, and Zip Code: ____
Office phone: __________________ fax: _____________________________________

Date of birth: __________________ Social Security #: ___________________________

Other names used: ____
Last time seen in your office: ____
Patient phone: ____

Reason for release: ___ Transfer of care ___ Consultation ___Copy for PCP ___Other

Release:

___ All Medical Records	___ Radiology	___ Prenatal records
___ Lab reports	___ Operative Reports	___ Hospitalizations

Please send my records to:

Dr. Karen Goodrich
1428 Phillips Lane, Suite 201
San Luis Obispo, CA 93401
805.548.8545 phone
805.548.8548 fax

Duration: I understand that this authorization may be revoked in writing at any time, according to the instructions outlined in the Notice of Privacy Practices for the office of Karen Goodrich, M.D., except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six months from the date of its authorization.

I hereby release the office of Karen Goodrich, M.D. from any/all legal liability that may arise from the release of this information to the party named above.
Patient signature: ______________________________ Date: ____________________
Parent/legal guardian:____________________________ Date: ____________________
***In the event that the patient transfers care to a new physician, and requests a records release, these records will also be transferred unless indicated below.
_________ Do not forward these records. I prefer to be contacted directly.