# Authorization For Release of Medical Records

I, ______________________________ authorize release of my medical records from:

Dr. Karen Goodrich
1428 Phillips Lane, Suite 201
San Luis Obispo, CA 93401
805.548.8545 phone
805.548.8548 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
___ Please release my medical records to myself. (Please list name and fax number below).

Release:

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

Please send my records to:
Name: __________________________________________________________________________
Address: ________________________________________________________________________
_________________________________________________________________________________
Office phone number: ____________________ Office fax number: _______________________

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 information to the party named above.

***I acknowledge that records sent to this office from a prior physician will not be forwarded to a new office. Please contact past physicians for copies of past medical records.

Patient signature: ____________________________________________ Date: _____________
Parent/legal guardian: _________________________________________ Date: _____________