AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, the undersigned, _____,
(Patient's name)
hereby authorize UCHC to release my complete medical records including the diagnosis,

treatment, X-rays and tests performed from _____
(start date)
through _____ to _____
(end date) (name of physician/medical facility)

located on _____
address of physician/medical facility

_____ _____
(telephone number) (fax number)

Patient's Signature: _____ Date: _____

Medical Record #: _____ Date of Birth: _____

Witness: _____ Date: _____

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[ ] 1501 E. Holt Ave. #A * Pomona, CA 91767 * Tel (909) 623-3600 * Fax (909) 623-3383
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