RIPON FAMILY PHYSICIANS

521 N WILMA AVENUE STE A
RIPON, CA 95366

TELEPHONE 209-599-4211
FAX 209-599-7348

www.RiponFP.com

Medical Records Release Form

I hereby authorize Ripon Family Physicians to send records and information to:
Name: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____ Fax: _____

PRINT Patient's Full Name: _____

_____ _____ _____
Medical Record # Date of Birth Phone Number

_____
Address City State & Zip

SPECIFIC REQUEST:
☐ **ONE YEAR OF COMPLETE RECORDS**, unless specified below.
(Send the most recent 12 months that the patient was seen.)
Additionally:

☐ Most recent labs
☐ Most recent Colonoscopy/Endoscopy
☐ Most recent Pap smear pathology
☐ Most recent Mammogram
☐ Immunization Record
☐ Drug/Alcohol/Substance abuse records
☐ Psychiatric/Mental health records
☐ HIV/STD results
☐ Genetic Information

OTHER _____

PURPOSE: ☐ Transfer of Care ☐Personal ☐Other_____

Duration: This authorization is effective immediately and will remain in effect for one year from the date of signature, unless a different date is specified here: _____. The recipient of this protected health information will not re-disclose the information, except with a written authorization or as specifically required or permitted by law. Upon request, the patient will receive a copy of this completed authorization form. This authorization is subject to written revocation by the patient at any time. A copy of this authorization is as valid as the original.

_____ _____
Signature Relationship to patient

_____
Date

Faxed: Date & Initials