



Medical Records Release Form

Please fax my records from:

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I hereby authorize that you release my medical records to: Ripon Family Physicians
521 N Wilma Ave Ste A • Ripon CA 95366 • Phone: 209-599-4211 • Fax: 209-599-7348

Please fax the records OR send on disk.

PRINT Patient's Full Name: _____

Date of Birth Phone Number Medical Record #, if known

Address City State & Zip

SPECIFIC REQUEST:

- Chart Summary, Problem List, Surgical History, Current Medications/Allergies*
- Progress notes (1 year)
- Immunization Record
- Most recent labs
- Colonoscopy/Endoscopy + pathology (adults)
- Most recent Pap smear pathology (women)
- Most recent Mammogram (women)
- Drug/Alcohol/Substance abuse records
- Psychiatric records
- HIV/STD results
- Genetic Information

OTHER

Purpose: At the request of the individual.

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.

The covered entity may not condition treatment or payment upon whether the individual signs the authorization.

Signature Date Relationship to patient, (if different)

Faxed: Date & Initials