PACIFIC GROVE
FAMILY MEDICINE

AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS

I hereby authorize:

_____

Name of Doctor or Medical Group Phone/Fax Number

to furnish medical records concerning the following patient(s) for the purpose of continuing healthcare/treatment:

Name: _____ **DOB:** _____

Name: _____ **DOB:** _____

Name: _____ **DOB:** _____

Name: _____ **DOB:** _____

To: **Pacific Grove Family Medicine**
Eliot Light, M.D. and Siang Lo, D.O.
621 Forest Avenue
Pacific Grove, CA 93950

Tel (831) 649-1011
Fax (831) 920-4506

Please DO NOT FAX any medical records OVER 25 PAGES.
Thank You!

Please include the following:

( ) All records including lab tests, radiology studies, and reports

( ) Other/Specific: _____

Any and all information may be released, including but not limited to: mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results if any, except as specifically stated below:

_____

I understand that I may receive a copy of this authorization.

Signed: _____ **Date:** _____

If not signed by the patient, please indicate relationship:
( ) Parent or guardian of minor patient
( ) Guardian or conservator of incompetent
( ) Beneficiary or personal representative of deceased patient