EASTLAKE FAMILY
MEDICAL
2452 Fenton Street, Suite 301
Chula Vista, CA 91914
Tel: 619-946-4073 * Fax: 619-946-7243
clinic@eastlakefamilymedical.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
COPIES ONLY

This is to certify I give permission to named medical provider for release of medical records (**COPIES ONLY**) to be sent to Eastlake Family Medical.

NAME OF THE PROVIDER/CLINIC: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: _____

FAX NUMBER: _____

NAME OF PATIENT: _____

D.O.B. _____

SPONSOR SSN (if applicable): _____

SPECIFY INFORMATION REQUESTING:

Complete Medical Records _____
Laboratory Results _____
Radiology Results _____

PLEASE CIRCLE ONE

1. **MAIL TO ABOVE ADDRESS**
2. **PATIENT TO PICK UP**
3. **FAX TO ABOVE**

_____ **DATE:** _____
(SIGNATURE OF PATIENT/PARENT OR LEGAL GUARDIAN)

Please note: this request is good for one year from the date it was signed by patient. Thank you.