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www.mvmedicine.com

Medical Records Release and Authorization Use or Disclosure of Protected Health Information

Patient Name	
Address	
City, State, Zip	
Phone	
Date of Birth	

I authorize the custodian of records of

Doctor's Name: ____

Office Address: ____

Phone Number: ______________________________ Fax Number: ______________________________

To release the following information:

- ☐ All Records
- ☐ Laboratory/Pathology records
- ☐ X-Ray/Radiology Records
- ☐ Billing Records
- ☐ Pharmacy/Prescription Records
- ☐ Other (please specify)

Please send records to:

Marina Village Medicine
1050 Marina Village Parkway,
Suite 101
Alameda, CA 94501

Tel: (510) 227-5540
Fax: (510) 788-6849

By signing below, I represent that I have authority to sign this document and authorize the use or disclosure of protected health information:

____ _______________________________
Signature of Patient or Patient's representative Date

____ _______________________________
Print name of Patient or Patient's representative Date