AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO DR KLAUSNER

Release records from _____

(Name of doctor, clinic, hospital)

Address _____

Phone _____ Fax _____

I, _____ _____ request that my medical records be released to:

Patient's Name Date of Birth

Dr. Warren Klausner
129 Jewell Street
Santa Cruz, CA 95060
831.420.1400
831.420.1401(Fax)

Please release the following information:

- ☐ X-rays, MRI, CT Reports
- ☐ Lab results
- ☐ Complete medical record

I understand that I have a right to receive a copy of this authorization upon my request.

Copy requested? Yes ☐ No ☐

Patient signature _____ Date _____

Signed by ☐ Patient ☐ Spouse ☐ Parent ☐ Guardian

_____