MEDICAL RECORDS RELEASE REQUEST

USE OR DISCLOSURE: I hereby authorize: _____ _____

PROVIDER/FACILITY NAME PHONE #

_____

PROVIDER/FACILITY ADDRESS

TO RELEASE HEALTH INFORMATION TO: CHRISTOPHER A SIMMONS, MD
1027 BROWN AVE.
LAFAYETTE, CA 94549
PHONE #: (925)273-7508
SECURE FAX #: (925)209-2995
EMAIL: CASIMMONSMD@CHRISTOPHERASIMMONSMD.COM

REQUESTED FORMAT: ENCRYPTED EMAIL OR CD IF AVAILABLE, IF NOT, PLEASE FAX OR MAIL RECORDS

HEALTH INFORMATION YOU AUTHORIZE TO BE RELEASED (PLEAE INITIAL NEX TO ALL THAT APPLY)**:**

_____ **Outpatient records (including lab results and imaging and immunizations)**

_____ **Hospital records (including lab results and imaging and immunizations)**

_____ **Information pertaining to drug and alcohol abuse, diagnosis or treatment**

_____ **Information pertaining to mental health diagnosis or treatment**

_____ **Release of HIV test results**

_____ **Release of genetic testing information**

PATIENT INFORMATION:

PRINT PATIENT NAME: _____ **DATE OF BIRTH:** _____

PHONE #: _____ **DATE:** _____ **TIME:** _____

PATIENT/LEGAL REPRESENTITIVE SIGNATURE: _____

PRINTED NAME OF LEGAL REPRESENTITIVE (IF OTHER THAN PATIENT): _____

RELATIONSHIP: _____