AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Gregory Jenkins, M.D.
23206 Lyons Ave. Suite 209, Newhall, CA 91321
P: 661-600-9494 F: 877-646-7426

1. PATIENT INFORMATION

Patient name_____ Date of Birth_____

Patient Phone _____ Medical Record # (if known) _____

2. INFORMATION TO BE RELEASED FROM

Organization/Person: __Gregory Jenkins, M.D._____

Address__23206 Lyons Ave., Suite 209_____ City, State, Zip __Newhall, CA 91321_____

Phone____(661) 600-9494_____ Fax ___(877) 646-7426_____

3. INFORMATION TO BE RELEASED TO

Organization/Person: _____

Address: _____

Phone: _____ Fax: _____

4. PURPOSE OF RELEASE

Continuing care _____ Copies for own use_____ Other (Specify) _____

5. INFORMATION TO BE RELEASED

Please specify what records you are requesting for release:

All Records _____

Date from: _____ to: _____

Evaluation/Progress notes___ Lab Reports____ Radiology & other Diagnostic Images_____

Other:_____

6. SIGNATURE

_____
Signature of Patient / Legal Representative

_____ _____
Printed Name Date

_____
(If signed by someone other than the patient, indicate relationship to the patient)

_____ _____
Signature of Witness/interpreter (only if patient is unable to sign) Date