

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Release records from: \_\_\_\_\_

(Name of doctor, clinic, hospital)

Address: \_\_\_\_\_

Phone and Fax No.: \_\_\_\_\_

I, \_\_\_\_\_, request that my medical records be released to:  
(Patient's name and Date of Birth)

Dr. Warren Klausner  
129 Jewell Street  
Santa Cruz, CA 95060  
PH: 831. 420. 1400  
Fax: 831. 420. 1401

### 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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signed by:  Patient  Spouse  Parent  Guardian