PATIENT AUTHORIZATION TO RELEASE RECORDS

Name of Patient: ___________________________________ DOB: _______________

For Transfer of Records From:

Name of Facility: ____

Address: ____

____

Phone: ___________________________ Fax: _______________________________

To:

Humphrey Lu, MD

640A Purissima Street

Half Moon Bay, CA. 94019

T: (650) 560-9137 F: (650) 560-9138

I hereby authorize transfer of information for purposes of medical care and/or consultation:

All Records OR Limited to the following: _____________________________

Signature of Parent/Guardian: ____

Printed Name of Parent/Gaurdian: ____

Date: _________________________

Updated December 2015