

HEALTH & WELL-BEING

MEDICAL/MENTAL HEALTH RECORDS REQUEST AND RELEASE FORM

Tel: (310) 243-3629 Fax: (310) 928-7142

Attention: The patient must complete this form in its entirety in order for any healthcare facility to release medical information. The patient must be specific as to the nature of the information he/she would like released and the purpose for which it is requested. Please initial options.

BEING FOLLOWED BY CSUDH- HEALTH & WELL-BEING CENTER BEING FOLLOWED BY OUTSIDE PHYSICIAN INSURANCE EMPLOYMENT OTHER (SPECIFY) PLEASE RELEASE MEDICAL RECORDS TO: (Please initial options) PATIENT CSUDH HEALTH & WELL-BEING A-129, 1000 E. VICTORIA STREET, CARSON, CA 90747 OTHER (SPECIFY: NAME, ADDRESS & ZIP CODE) Please call me when records are ready to be picked up Please call me when records are ready to be picked up I will pick up records Fax records as requested (DATE:						
I, THE UNDERSIGNED, HEREBY AUTHORIZE THE: (Please initial options) CSUDH - HEALTH & WELL-BEING OTHER HEALTH & WELL-BEING OTHER FOLLOWING RECORDS PERTAINING TO MY HEALTH: (Please initial options) ALL RECORDS HISTORY AND PHYSICAL FORM ONLY - SPECIFY DATE(S) SUMMARY OF RECENT CARE INCLUDING PATIENT VISITS, LABORATORY RESULTS, X-RAY, DIAGNOSIS AND TREATMENTS. SPECIFY DATE(S) TB CLEARANCE MOST RECENT ALL PREVIOUS TESTS MENTAL HEALTH RECORDS OTHER (SPECIFY) FOR THE FOLLOWING REASON(S): (Please initial options) BEING FOLLOWED BY OUTSIDE PHYSICIAN INSURANCE EMPLOYMENT OTHER (SPECIFY) OTHER (SPECIFY) PATIENT CSUDH HEALTH & WELL-BEING A-129, 1000 E. VICTORIA STREET, CARSON, CA 90747 OTHER (SPECIFY) PATIENT CSUDH HEALTH & WELL-BEING A-129, 1000 E. VICTORIA STREET, CARSON, CA 90747 OTHER (SPECIFY) Mail records as requested Please call me when records are ready to be picked up I will pick up records Mail records as requested Gas Naviers Gas Naviers Patient Signature Patient Signat	(Please Print) LAST NAME	FIRST NAME	MI		DATE OF BIRTH	ID#	
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