Request for Release of Medical Records & Pathology Material

URGENT

Physician/Hospital Name: _____

_____

Address: _____

_____

_____

Dates of Hospitalization: _____ thru _____

Date: _____

Patient Name: _____

Date of Birth: _____

Patient or Guardian Signature: _____

Guardian Name: _____

Relationship to Patient: _____

I hereby request any and all of the following medical records in your possession:

- ☐ Imaging Reports
- ☐ Laboratory & Pathology Results
- ☐ Pathology Material
- ☐ Physicians Office Records
- ☐ Hospital Records
- ☐ HIV Test Results
- ☐ Mental Health Records Protected by Lanterman-Petris –Short Act
- ☐ Other: _____

The authorization is effective now and will remain in effect until one year from date signed.

If not signed by patient, please indicate the relationship:

- ☐ Parent or guardian of a minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of a deceased patient
- ☐ Spouse or person financially responsible –where information is solely for the purpose of processing an application for dependent health care coverage

For mental health records only:

Physician Signature: _____

Date: _____

To be released and faxed to:

Comprehensive Blood & Cancer Center
6501 Truxtun Avenue
Bakersfield, CA 93309
Fax: **(661) 322-7027**