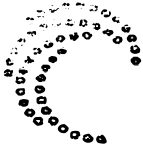

Marina Village Medicine

Request Sent:
1st: __________
2nd: __________

General Medical Records Release and Authorization
Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name	
Address	
City, State, Zip	
Phone	
Date of Birth	

I authorize the custodian of records of:

Doctors Name____

Address ____

Phone___________________________ Fax ___________________________

To release the following information:

- ☐ All Records
- ☐ Laboratory/Pathology Records
- ☐ X-ray/Radiology Records
- ☐ Billing Records
- ☐ Pharmacy/Prescription Records
- ☐ Other (describe specifically)

____

Please send records to:
Marina Village Medicine
1050 Marina Village Pkwy
Suite 101
Alameda, CA 94501
Phone: 510-227-5540
Fax: 510-788-6849

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information:

____ ________________

Signature of patient (or patient's personal representative) Date

____ ________________

Print Name of Patient Representative's authority to sign for patient (I.e. parent, guardian, power of attorney for healthcare, executor) Relationship

The information contained in this transaction may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original document.