RECORDS TRANSFER REQUEST

TODAY'S DATE: _____

I AM REQUESTING THE RELEASE OF MY RECORDS FROM

_____

(DOCTOR / HOSPITAL)

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

I HEREBY GIVE AUTHORIZATION TO RELEASE PORTIONS OF MY MEDICAL RECORDS FROM _____ THROUGH _____ .

(DATE) (DATE)

- ☐ DOCTOR'S NOTES
- ☐ CONSULT NOTES
- ☐ L AB RESULTS
- ☐ HIV TESTS
- ☐ EKG REPORTS
- ☐ X-RAY REPORTS
- ☐ MRI OR CT REPORTS
- ☐ DISCHARGE SUMMARIES
- ☐ OTHER _____

PLEASE TRANSFER MY RECORDS TO:

L AURA EVANS, M.D.

529 W. Sierra Madre Blvd. - Sierra Madre, C A 91024

Phone: (626) 605-3434 Fax: (626) 355-3252

PATIENT NAME: _____

(L AST, FIRST, MIDDLE)

DATE OF BIRTH: _____

SIGNATURE: _____

(PATIENT, PARENT, OR GUARDIAN)

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