Medical Records Release Form

I, _____, DOB ___/___/___ hereby request and authorize

Mitchell L. Seitz, M.D.
632 W 11th Street, Ste. 111
Tracy, CA 95376
Phone (209) 833-7135 Fax (209) 833-3827

to release my entire medical record including: Problem List, Medication List, X-ray reports, and Doctor's notes to:

_____
(Name of Doctor to receive records)

_____
Address City, State Zip

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____.

REVOCATION: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

This authorization applies to the following information:

[ ] Any part of my medical record from (enter dates)
_____.

[ ] The following records or types of information (include dates of treatment)_____.

The recipient may use my health information only for the following purposes: (not required when the patient is the recipient).

[ ] Continuing care. [ ] Other. (Specify)_____

_____ _____
Signature Date