RIPON Family Physicians

Daryl Dutter, M.D. Kent Hufford, M.D. J. Jeffrey Daley, M.D.

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Medical Records Release Form

ATTN: MEDICAL RECORDS, Please fax records from: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____ Fax: _____

I hereby authorize that you release my medical records to:
Dr. Dutter, Dr. Hufford, and Dr. Daley
PO Box 210 ● Ripon CA 95366 ● Phone: 209-599-4211 ● Fax: 209-599-7348

PRINT Patient's Full Name: _____

_____ _____ _____
Medical Record # Date of Birth Phone Number

_____
Address City State & Zip

SPECIFIC REQUEST:
ONE YEAR OF COMPLETE RECORDS, unless specified below (Send the most recent 12 months that the patient was seen)
Additionally:

☐ Most recent labs
☐ Most recent Colonoscopy/Endoscopy – with pathology
☐ Most recent Pap smear pathology
☐ Most recent Mammogram
☐ Immunization Record
☐ Drug/Alcohol/Substance abuse records
☐ Psychiatric/Mental health records
☐ HIV/STD results
☐ Genetic Information

OTHER _____

Duration: This authorization is effective immediately and will remain in effect for one year from the date of signature, unless a different date is specified here: _____. The recipient of this protected health information will not re-disclose the information, except with a written authorization or as specifically required or permitted by law. Upon request, the patient will receive a copy of this completed authorization form. This authorization is subject to written revocation by the patient at any time. A copy of this authorization is as valid as the original.

_____ _____
Signature Relationship to patient

_____
Date

Faxed: Date & Initials