RIPON Family Physicians

Medical Records Release Form

Please fax my records from:

_____

Address: _____City: _____State: _____Zip: _____

Phone: _____ Fax: _____

I hereby authorize that you release my medical records to: Ripon Family Physicians
PO Box 210 ● Ripon CA 95366 ● Phone: 209-599-4211 ● Fax: 209-599-7348

Please fax the records OR send on disk.

PRINT Patient's Full Name: _____

_____ _____ _____
Date of Birth Phone Number Medical Record #, if known

_____
Address City State & Zip

SPECIFIC REQUEST:

☒ **Chart Summary, Problem List, Surgical History, Current Medications/Allergies**
☒ Progress notes (1 year)
☒ Immunization Record
☒ Most recent labs
☒ Colonoscopy/Endoscopy + pathology (adults)
☒ Most recent Pap smear pathology (women)
☒ Most recent Mammogram (women)

☐ Drug/Alcohol/Substance abuse records
☐ Psychiatric records
☐ HIV/STD results
☐ Genetic Information

OTHER _____

Purpose: At the request of the individual.
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.
The covered entity may not condition treatment or payment upon whether the individual signs the authorization.

_____ _____
Signature Date Relationship to patient, (if different)

Faxed: Date & Initials