AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: Doctor's Name: _____
Phone: _____ Fax: _____

I, _____ with DOB: _____/_____/_____ authorize you to release confidential health information about me, by faxing a copy of my requested medical records to Dr. Michael W. Cluck, MD, PhD at 408-295-2202.

The information you may release subject to this sign release form is as follows:

- ☐ Complete Medical Record
- ☐ Op Reports
- ☐ Complete Progress Reports
- ☐ Radiology Reports
- ☐ Other (please specify) _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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