Central Coast Oncology & Hematology

Amy McMullen, MD Michael Yen, MD PhD

Authorization for Release of Medical Records

Patient Information (please print)
Name _____ DOB _____
Address _____
City _____ State _____ Zip _____
Phone _____ Email _____

Release my medical records *FROM*
□ Central Coast Oncology & Hematology □ Other (below)
Name_____
Address_____
City _____ State _____ Zip _____
Phone _____ Fax _____
Records should include: □ All records
Limited to specific records:_____

Release my medical records *TO*
□ Central Coast Oncology & Hematology □ Other (below)
Name_____
Address_____
City _____ State _____ Zip _____
Phone _____ Fax _____
Records should include: □ All records
Limited to specific records:_____

Signature required on page 2

Central Coast Oncology & Hematology

Amy McMullen, MD Michael Yen, MD PhD

Authorization for Release of Medical Records

Please release my records via the following method:

□ Mail □ Fax □ Non-encrypted email (not secure)

By my signature I authorize release of my medical records

_____

Signature

Signature required on page 2