Medical Records Release

Name: ____
LAST FIRST MIDDLE

Address: ____

Phone#________________ Date of Birth_________________ SS#________________

Purpose: (check one) ○ Transfer of primary care physician ○ Consultation ○ Personal

Information Requested:

- ☐ Recent Progress Note
- ☐ Most recent history and physical and discharge summary
- ☐ Recent lab results (two years)
- ☐ Cardiac Testing (EKG, Treadmill, Echo)
- ☐ Endoscopy Report
- ☐ Other Diagnostic Test Results
- ☐ Entire Medical Records (last 5 years)
- ☐ Other:

I authorize the release of all information indicated and I am aware that the records release may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

I authorize the release of HIV/AIDS test results ○ YES ○ NO

I understand that I am entitled to a copy of this upon request.
I have received a copy of this request. ○ YES ○ NO

I understand that California state law permits me to inspect or obtain copies of my medical records. I further understand that I may be charged for the copies provided.

This authorization will expire two years from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the office of J. Dustin Bernard, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

______________________________________ ____________________
Signature of patient, guardian, conservator, or patient's representative Date

______________________________________ ____________________
Witness Date

Please send the above information to: Information Requested from:

J. Dustin Bernard, DO

2074 Parker St., Suite 120

San Luis Obispo, CA 93401

805-546-9911 Phone

805-546-9933 Fax