

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: Richard Patragnoni, M.D., Inc.
355 Placentia Ave, Suite 307
Newport Beach, CA 92663

From: _____
Name of Patient

Re: Request for Release of Medical Records

I hereby request that my medical records, without limitations, including any HIV test results and/or treatment and any psychiatric records, be released to:

To: _____
Name of Physician, Hospital or Facility

Address: _____
Address City State Zip Code

Phone: _____ Fax: _____

This authorization releases my medical records for the following designated purpose:

This release is valid for 30 days after this date.

I understand that there is a \$25 charge to prepare and send my electronic medical records.

Signature of Patient or Legal Guardian Patient's Date of Birth

Print Patient's Name Date Signed

Print Name of Legal Guardian (relationship), if applicable Witness