Medical Release Form

To: _____
(Physician/ Medical Group)

Address: _____

City: _____ **State:** _____ **Zip:** _____

PH: _____ **FAX:** _____

PLEASE RELEASE RECORDS AS FOLLOWS:

Last 5 years - chart notes, consult notes, labs, x-rays and special tests
& most recent Colonoscopy, Mammogram, PAP & Immunizations

Other: _____

TO: Pacific Family Medicine

Catou Greenberg MD
Karen Kim DO
Carol Shi MD

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Ph: (949) 718-9020
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Patient's Name: _____ **Date Of Birth** ____/____/____

Signature: _____ **Date:** ____/____/____

Relationship To Patient: _____