CENTRAL COAST FAMILY CARE
MEDICAL ASSOCIATES OF SANTA MARIA, INC.

RECORDS RELEASE FROM:

Date requested: _____

FROM DOCTOR OR HOSPITAL: _____

Address: _____

City, State, Zip: _____

Phone number: _____

I HEREBY AUTHORIZE AND REQUEST TO RELEASE TO:

Central Coast Family Care
220 S Palisades Ave, Suite 104
Santa Maria, California 93454
Phone: (805) 925-2521 Fax: (805) 925-8721

_____**Brian Desmond, M.D.**
Board Certified in Family Practice

_____ **Laura J. Theis, M.D.**
Board Certified in Family Practice

_____ **Adrienne Dingler, NP**
Certified Nurse Practitioner

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS

AND OR TREATMENT DURING THE PERIOD FROM_____ TO_____

Including the following if initialed, but not limited to:

_____ Substance Abuse

_____ HIV disease/ AIDS

_____ Mental Health

_____ Developmental disabilit

* THIS FORM WILL EXPIRE 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED

NAME: _____Date of birth:_____

ADDRESS: _____ Phone: _____

SIGNATURE: _____
(IF RELATIVE STATE RELATIONSHIP)

WITNESS: _____
(IF RELATIVE STATE RELATIONSHIP)