RECORDS RELEASE INFORMATION.

Date requested: _____

FROM: _____
DOCTOR OR HOSPITAL

_____
ADDRESS

_____
City, State, Zip

_____
Phone number

I HEREBY AUTHORIZE AND REQUEST TO RELEASE TO:

Central Coast Family Care
821 E. Chapel Street, Suite 203
Santa Maria, California 93454
Phone: (805) 925-5334 Fax: (805) 922-5923

☐ **Michael P. Schrager, M.D.**
Board Certified in Family Practice

☐ **Richard L. Zachrich, M.D.**
Board Certified in Family Practice

☐ **Barbara Armstrong, FNP**
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 disability

* 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)