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
355 Daniel Drive #105
Santa Maria, CA 93454
Phone: (805) 937-3688 Fax: (805) 937-6822

Kamlesh M. Desai, MD
Board Certified in Family Medicine

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 NUMBER:_____

SIGNATURE: _____
(IF RELATIVE STATE RELATIONSHIP)

WITNESS: _____ **DATE:** _____
(IF RELATIVE STATE RELATIONSHIP)