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
1505 . Shepard Drive, Suite 104
Santa Maria, CA 93454
Phone: (805) 928-2645 Fax: (805) 928-1995

Mohammad A. Arain, M.D.
Board Certified in Internal 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: _____

SIGNATURE: _____
(IF RELATIVE STATE RELATIONSHIP)

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