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

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
915 E. Stowell Road, # B
Santa Maria, California 93454
Phone: (805) 938-7444 Fax: (805) 938-7422

_____ **John P. Okerblom, M.D.**
Board Certified in Family Practice

_____ **Melinda Jezierski, M.D. PhD**
Board Certified in Family Practice

_____ **Eric Sincoff, D.O.**
Board Certified in Family Practice

_____ **Scarlett Okerblom, PA-C**

_____ **Diana Agraz, PA-C**

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)