REQUESTED:
Doctor/Facility Name: ____
Address: ____
Phone: ____________________________ Fax (must have): _____________________
PLEASE FORWARD MY MEDICAL RECORDS AS REQUESTED BELOW TO:

Burrows Family Practice, Inc.
1377 S. Grand Ave Glendora, CA 91740
Phone: 626-483-3348 Fax: 626-623-7258

NOTE: Hospital and medical office records may include information related to mental health, alcohol/drug, and HIV references. The actual treatment records from mental health and/or alcohol/drug departments, and/or results of HIV tests will not be disclosed unless specifically requested below.

□ Medical Office Records dated from __________ to __________
□ Hospital Records dated from __________ to __________

SIGNATURES AND DATES REQUIRED IF ANY OF THE FOLLOWING BOXES ARE CHECKED

□Mental Health dated from ________ to ________Signature: ______________________ Date: ________
□Alcohol/Drug dated from ________ to _________Signature: ______________________ Date: _______
□HIV Results dated from ________ to ________Signature: ______________________Date: ___________

□ Lab results dated from________ to _________□ Radiology results dated from_______ to____________
□ Pathology results from_______ to __________□ Operative reports □ Immunizations Records
□ Procedure reports (i.e. colonoscopy, EGD, sleep study, echo, stress test etc)

Duration: This authorization is effective immediately and shall remain in effect for one year from signature of date.
Revocation: This authorization may be revoked in writing at any time prior to the release of my information. Written revocation will not affect any action that has taken place before the receipt of the written revocation.
Disclosure: I understand that Burrows Family Practice may not lawfully further use or disclose this health information unless another authorization is obtained from me, or unless disclosure is specifically required or permitted by law.
Patient Name: _________________________________Date of Birth: ____________________________
Home Address: ____
X____ Date__________________________________
(Patient, parent or guardian signature required)

- **A copy of this authorization is valid as an original only**