



Authorization For Release of Records

To: _____

Address: _____

Phone: _____

Please Release The Following Records:

- Medical History
- X-ray Reports
- Surgical Reports
- Lab Reports
- Other _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse, and/or behavioral or mental health services.

Dates of Service from: _____ to: _____

Release Information To: Erik G. Palmer, D.O., *Medical Director*
Van T. Nguyen, M.P.A.S., PA-C, *Certified Physician Assistant*
555 E. Tachevah Suite 2W-203
Palm Springs, CA 92262
(760) 323-4272 Office
(760) 323-8597 Fax

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Patients Signature: _____ Date: _____

Please Mail Fax Information

This authorization will expire in 90 day from the date signed.

CONFIDENTIAL: This important in intended for the use of the individual or entity names on this transmission sheet. If you are not intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in the reliance on the contents of the faxed information is strictly prohibited, and the documents should e returned to our office immediately.