MEDICAL RECORDS REQUEST

I hereby authorize the use and disclosure of protected health information from:

Provider Name:_____ Phone:_____
Address:_____ Fax:_____

to be furnished to: **David Bruce Christian, M.D.**
500 Old River Road, Suite 145
Bakersfield, CA 93311-9509
(661) 664-0434 Phone
(661) 664-0432 Fax

Information requested for the purpose of: ☐ **Healthcare** ☐ Insurance Coverage
☐ Personal ☐ Other: _____

Please *initial* next to the category of information you wish to have released to us:

initial All of my health information pertaining to any medical history, physical condition and treatment received.
initial All records for the last 2 years
initial Last Progress Note(s)
initial Radiology/Imaging Reports
initial Consultation Reports
initial Laboratory/Pathology Reports
initial Other Medical records relating to injury

Disclosures requiring special consent: My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis or treatment for *(initial applicable headings):*

initial HIV/AIDS virus
initial Drug / Alcohol Abuse Treatment
initial Mental Health / Psychiatric Disorders
initial Sexually Transmitted Disease

This authorization will expire on: _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. (Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or the discretionary provisions of California Civil Code #56.10(x) may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.)

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. Imay inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this information.

Please fill in the box below

Patient Name: _____
Address: _____
City: _____ State:_____ ZIP: _____
Birthdate: ____/____/____ Phone: _____
Social Security #: ____-____ - ____ Maiden/Other Name: _____

_____ _____
Signature of Patient or Responsible Party Date