MEDICAL RECORDS REQUEST

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

Doctor's Name:____________________________________ Phone:____________________
Address:____ Fax:______________________

to be furnished to **David Bruce Christian, M.D.** via paper, secure fax, or CD-ROM (**PDF** files only)**:**

at: 500 Old River Road, Suite 145 — (661) 664-0434 Phone
Bakersfield, CA 93311-9509 — (661) 664-0432 Fax
claire@dbchristian.com

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 inaccordance 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