

Request for Release of Medical Records & Pathology Material

URGENT

Physician/Hospital Name: _____

Address: _____

Dates of Hospitalization: _____ thru _____

The authorization is effective now and will remain in effect until the date of _____.

Patient Name: _____

Patient Signature: _____

Date of Birth: _____

Date: _____

I hereby request any and all of the following medical records in your possession:

- Imaging Reports
- Laboratory & Pathology Results
- Pathology Material
- Physicians Office Records
- Hospital Records
- HIV Test Results
- Mental Health Records Protected by Lanterman-Petris - Short Act
- Other: _____

If not signed by patient, please indicate the relationship:

- Parent or guardian of a minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of a deceased patient
- Spouse or person financially responsible - where information is solely for the purpose of processing an application for dependent health care coverage

For mental health records only:

Physician Signature: _____

Date: _____

To be released and faxed to:

Comprehensive Blood & Cancer Center
6501 Truxtun Avenue
Bakersfield, CA 93309
Fax: **(661) 322-7027**

CBCC COMPREHENSIVE
BLOOD & CANCER CENTER
Outsmarting Cancer™