Request for Release
Of
Medical Records & Pathology Material

* URGENT *

_____

Physician/Hospital's Name

_____

Address

Dates of Hospitalization: _____ through _____

I Hereby Request any and all of the Following Medical Records in your possession:

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

To Be Released and Faxed To:

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

The authorization is effective now and will remain in effect until _____(Date).

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Patient Signature Date

If not signed by patient, please indicate the relationship:

- o Parent or guardian of a minor patient
- o Guardian or conservator of an incompetent patient
- o Beneficiary or personal representative of a deceased patient
- o 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:

Signed: _____ Date: _____

Treating Physician

UCLA Affiliated Medical Center · **Website: www.cbccusa.com**
6501 Truxtun Avenue · Bakersfield, CA 93309 · (661) 322-2206 · FAX (661) 322-7027
1310 Las Tablas Road, Suite 204 · Templeton CA 93465 · (805) 434-0333 · FAX (805) 434-0893