Westside Primary Care Associates

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Medical Records Release Form

I, _____ authorize the following physicians:

Name: _____

Address: _____

City; State; Zip Code: _____

To Release my medical records including all confidential and communicable disease related information to: WPCA (Westside Primary Care Associates) at the above address.

The information you may release subject to this signed release form is as follows:

☐ Complete Records	☐ History & Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Reports	☐ Medication Record	☐ Other (please specify below)

********** DO NOT FAX RECORDS IF MORE THAN 10 PAGES**********

The purpose/reason for this release of information is as follows:

_____

Signature:

_____ _____

Patient Name — Signature of Patient or Personal Representative

_____ _____

Patient Date of Birth or Social Security Number — Printed Name of Patient or Personal Representative