Daryl Dutter, M.D. Kent Hufford, M.D. J. Jeffrey Daley, M.D.
150 Vera Ave, PO Box 210, Ripon CA 95366
Phone: (209)599-4211 Fax: (209)599-7348

Medical Records Release Form

I hereby authorize that my medical records be released to:

Dr. Dutter, Dr. Hufford, Dr. Daley
PO BOX 210, Ripon, CA 95366
Phone: (209)599-4211 Fax: (209)599-7348
Send records by fax only if less than 40 pages. If more than 40 pages, please send on CD.

Please send records from: _____
Physician's Name

_____
Address City State Zip

_____ _____
Phone Fax

Records and information pertaining to: _____
PRINT Patient's Full Name

_____ _____ _____ _____
Medical Record #, if applicable Date of Birth Phone Number

_____
Address City State Zip

Duration: This authorization is effective immediately and will remain in effect for one year from the date of signature, unless a different date is specified here: _____. The recipient of this protected health information will not re-disclose the information, except with a written authorization or as specifically required or permitted by law. Upon request, the patient will receive a copy of this completed authorization form. This authorization is subject to written revocation by the patient at any time. A copy of this authorization is as valid as the original.

Specific Request:

❒ **One year of complete records** (*most recent 12 months that the patient was seen*)
❒ Chart Summary ❒Problem List ❒Medication List
❒ Two years of records
❒ Most recent labs
❒ Most recent colonoscopy/endoscopy report
❒ Most recent pap smear report
❒ Most recent mammogram report
❒ Immunization record
❒ Drug/Alcohol/Substance Abuse records
❒ Psychiatric/Mental Health records
❒ HIV/STD testing records and results
❒ HIV diagnosis and treatment records
❒ Genetic Information
❒ Other _____

_____ _____
Signature Date
If signed by someone other than the patient, indicate your relationship to patient: _____

Faxed: Date & Initials_____