



# Moorpark Family Medicine

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## Authorization to Release Medical Information

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I, the above named patient, authorize

Moorpark Family Medicine

301 Science Drive

Suite 190

Moorpark, CA 93021

To release/receive my medical information to/from

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

The information should include (please circle)

Progress Notes

Labs/Pathology

Imaging

Consultations

ALL MEDICAL RECORDS

From the dates ranging between

\_\_\_\_\_ and \_\_\_\_\_

**Go green, please fax**

records to our fax server/EMR at (805) 531-9499

Signed \_\_\_\_\_

Date \_\_\_\_\_