Dannielle Harwood, M.D.
Women's Health & Family Medicine
1645 Esplanada, Suite 4, Chico CA 95926
Phone (530)343-1200
Fax (530)894-3107

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____

Date of Birth: _____

I hereby authorize:

_____
Name of Individual/Facility/Agency

_____
Address

_____
City, State Zip Code

Fax: _____

To release the following medical records:

____ All medical records

____Labs

____Immunizations

___ Treatments dates_____ to _____

____ Specific information as indicated: _____

Please fax to: STUDIO+MD
Dannielle Harwood, M.D. Family Medicine
1645 Esplanade Suite 4, Chico, CA 95926, Phone (530)343-1200, Fax (530) 894-3107

I further understand that I may revoke this authorization at anytime, except for action that has already been taken. This release will be effective for six months from date signed.

_____ _____
Signature (Parent or Legal Guardian if applicable) Date