CONSENT TO RELEASE MEDICAL RECORDS

Date:

I, _____, hereby authorize _____ to provide my medical records to the below named individual, agency or law enforcement agency. I understand that I have a right not to consent to the release of my medical records. I have the right to revoke this consent at any time by completing a revocation in writing.

Medical records to be released by my consent include all records without limitation.

The records shall be provided to or sent to:

John/Jane Doe
Ventura County John/Jane Doe Agency
123 Street
XXX, CA
John.doe@ventura.org
(805) 555-5555

Patient signature: _____Date: _____

Name:
Address:
DL:
SSN:
Telephone No.:
Email: