A division of BASS MEDICAL GROUP

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Phone: (408) 659-1865 • *Fax:* (408) 770-4727

Date: _____

Records Release

Patient: _____ DOB: _____

To Whom It May Concern:

I have an appointment today with my physician**.** I hereby authorize the release of all medical records pertaining to my current condition.

I understand that I have the right to revoke this authorization by submitting a letter to the office. This authorization expires one year after the date above.

Please fax my records to (408) 770-4727. Thank you.

Sincerely,

_____ _____

Patient's Signature *Date*

_____

Relationship to Patient (if applicable)