HealthCareInstitute MedicalGroup

ROY H. JACKSON, M.D.
Medical Director
65 North Madison Avenue, Suite 200
Pasadena, California 91101-2051
Telephone (626) 792-4185
Fax (626) 792-7358
Email: services@hcimed.com

Medical Records Release

Patient Full Name: _____

Last 4 digits of SSN: _____

DOB: _____/____/_____

Release Records From:	**I hereby authorize and request you to release my medical records to:**
_____	_____
_____	_____
_____	_____

The complete medical records in your possession concerning my illness and/or treatment during the period of:

From: _____ **To: _____**

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Signature of Individual or Guardian or Personal Representative of patient's estate

Signed: _____ **Date: _____/_____/_____**

Print Name: _____

MAIL OR FAX COMPLETED FORM TO:

HEALTH CARE INSTITUTE MEDICAL GROUP
65 N. MADISON AVE. #200
PASADENA, CA 91101
Phone: 626-792-4185 | Fax: 626-796-2488

Please allow 10 business days for completion of requests