peninsula doctor

Medical Records Release

Patient Name: _____

Date: _____

Date of Birth: _____

I hereby authorize (name of your current medical practice):

_____

_____

_____

To release copies of my medical records to be sent to:

Peninsula Doctor
Attn: Dr. Ian Kroes MD & Dr.Hiroshima
401 Burgess Dr. Suite D
Menlo Park, CA 94025

Phone 650.800.3365
Fax 650.252.0043 (Do not fax more than 15 pages)

Medical information includes:

_____ All records

_____ Radiology results only

_____ Lab results only

Medical information should exclude:

_____ Mental health records

Signature: _____