Central Coast Oncology and Hematology

Amy McMullen, M.D.
Giselle Salmasi, M.D.
Michael Yen, M.D., PhD.

Authorization for Release of Medical Records

Patient Information (please print)

Name ______________________________

SSN ______________________ DOB ______________________

Address ______________________________

City ______________________ State __________ Zip __________

Phone ______________________

Release my medical records *from*

☐ Central Coast Oncology & Hematology ☐ Other (below)

Name ______________________________

Address ______________________________

City ______________________ State __________ Zip __________

Phone ______________________ Fax ______________________

Release my medical records *to*

☐ Central Coast Oncology & Hematology ☐ Other (below)

Name ______________________________

Address ______________________________

City ______________________ State __________ Zip __________

Phone ______________________ Fax ______________________

Please release a copy of all my medical records including, but not limited to, progress notes, operative notes, laboratory results and diagnostic test.
By my signature I authorize release of my medical records.

______________________________ ______________________
Signature Date