ROSAASEN
Family Medicine

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Authorization to Release Medical Information

Patient Name _____

Date of Birth _____

I, the above named patient, authorize

Rosaasen Family Medicine
430 Avenida De Los Arboles Ste. 204
Thousand Oaks, CA 93021

To release/receive my medical information to/from

Name_____

Address_____

Phone_____

Fax_____

The information should include (please circle)

Progress Notes
Labs/Pathology
Imaging
Consultations
ALL MEDICAL RECORDS

From the dates ranging between

_____ and _____

Please go green and fax records to our fax server/EMR at (805) 492-2035

Signed_____

Date_____