

**AUTHORIZATION TO TRANSFER MEDICAL RECORDS**

I hereby authorize \_\_\_\_\_, M.D., to furnish medical information concerning [patient's name:] \_\_\_\_\_ to Dr. [physician's name and address:] \_\_\_\_\_.

Any and all information may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and alcohol abuse records, and HIV test results, if any, except as specifically provided below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[Optional:] I understand and agree to pay a reasonable charge to cover the cost the transfer. I understand the costs will be computed based on a copying fee of 25 cents per page for standard documents, actual costs for the reproduction of oversized documents or documents requiring special processing, and reasonable clerical costs for locating and making the records available.

This authorization is effective now and will remain in effect until [date:] \_\_\_\_\_.

I understand that I may receive a copy of this authorization.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient