CENTRAL COAST
MEDICAL GROUP
familiar faces with a new vision

Authorization to Release Medical Records

Patient Name:_____
First M.I. Last

Date of Birth:_____/_____/_____

I request and authorize: _____ to release the requested healthcare information to:

Central Coast Medical Group
1101 East Ocean Avenue, Ste. B
Lompoc, CA 93436

Requested Records:

_____EHR Medical summary if available

_____Immunization Record

_____Growth Chart (for patient under age 18)

_____Last Colonoscopy (if applicable)

_____Last DEXA (if applicable)

_____Most recent office visit

_____Most recent physical exam

_____Last Pap smear (if applicable)

Patient or guardian signature:_____

Date signed:_____/_____/_____