MERCED MEDICAL CLINIC, INC.
SATNAM S. UPPAL, MD
Internal Medicine & Gastroenterology

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650 W. Olive Ave
Merced, CA 95348

MEDICAL RECORDS RELEASE REQUEST

RE: Patient Name: _____

DOB: _____ Phone No: _____

MEDICAL RECORDS REQUESTED FROM:

TO: Facility/Provider Name: _____

Phone No: _____ Fax No: _____

Please send the following medical records to Merced Medical Clinic:

____ Past # _____ years of medical records (chart notes, tests, procedures, etc.)

____ Most recent complete History & Physical

____ Procedure/Testing/Surgical notes: _____

____ Past # _____ patient encounters (chart notes, tests, procedures etc.)

____ Insurance and Demographic Data (Face Sheet)

____ Dates covering from _____ to _____

PATIENT AUTHORIZATION:
I understand that my records may contain sensitive information. I give my specific authorization for the following information to be released. (EXCLUDE if initialed)

____ Substance abuse (drug/alcohol) ____ HIV/AIDS testing, diagnosis, treatment

____ Sexually Transmitted Infections ____ Mental Health/Psychiatric Records

I hereby request that the above records be sent to Merced Medical Clinic until I revoke my authorization by written request.

Signed: X_____ Date: _____
(patient, legal representative, guardian)

If not patient, please print name and relationship to patient:

Name: _____ Relationship: _____