

RECORD RELEASE/REQUEST

To _____
(Doctor/Hospital)

Address _____

City _____ State _____ Zip _____

I hereby authorize the release of my medical records,
for these dates: _____
or copies of such and request that they be transferred to:

Please circle the location you want your records transferred to

**AVENUE FAMILY PRACTICE
4333 Piedmont Avenue
Oakland, California 94611
Telephone (510) 654-2494
Fax (510) 654-2464**

**AVENUE FAMILY PRACTICE
911 Moraga Rd #101
Lafayette, CA 94549
Tel: 925-962-9120
Fx: 925-962-9120**

Patient _____
(Print Name of Patient)

Birthdate: _____

Patient's Signature OR Guardian NAME and signature

Date: _____