Foster City Medical Center
Primary Care and Urgent Care

MEDICAL RECORDS RELEASE AUTHORIZATION

Please fill out this form **COMPLETELY** and fax or mail to appropriate location.
Explanation: This authorization to receive or release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1980, section 56 et.seq. of the California Civil Code.

Patient's Name:_____ Date of Birth:_____

AUTHORIZATION:

I hereby authorize:

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone, Fax #:_____

Fax Records to: **FOSTER CITY MEDICAL CENTER**
(650) 403-6000

PLEASE INDICATE THE RECORDS YOU ARE RELEASING BELOW:

☐ All records ☐X-Ray report(s)
☐ Medications ☐EKG report(s)
☐ Lab report(s) ☐ Other:_____

DURATION: This authorization shall become effective immediately and shall expire 6 months from this date unless indicated otherwise or revoked earlier in writing.
RESTRICTIONS: I understand that this same information cannot be further released without any written consent and that no further authorization is made than is specifically indicated herein.

SIGNED:_____ **Date:_____**
(Patient or legal guardian)