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Christian Athanassious, M.D.
Neema Pourtaheri, M.D.
Thomas W. Axelrad, M.D.

Medical Records Request Form

PAITENT'S NAME:	***DOB:***

- My complete medical records (last two years)
- Only records from (date):_____ to (date):_____
- Only records for a specific type of care (like lab tests, op report, hospital etc.):_____

(Paper copy- $15.00 flat charge for personal records over 3 office visits, no charge if sent directly to outside physician.)

I hereby authorize the following healthcare to release my confidential medical information and records to the physician, person, facility listed below. Information and records regarding treatments of minor, HIV, psychiatric mental health conditions or alcohol substance abuse have special rules that apply and require specific authorization.

I authorize to release any and all records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

YES:	***NO:***

Medical Office:	***Self:***	***Other:***

Name: _____ | ***Pick up:*** | ***Mail:***

Address: _____

City/State/ZIP: _____ Phone:_____

Permission for further use or disclosure of this medical information is not granted unless another is obtained from me or unless such disclosure is specifically required or permitted by the law. A photocopy or facsimile of this authorization shall be considered as an effective and valid original document.

Patient's Signature: _____ **Today's Date:** _____

ID VERTIFIED BY: _____ *(Front desk use only)* MD's Initials: _____

This form expires 1 year after signed.

Please fax this form to (707)-546-1897

03/09/2020