Josefa M. Rangel, M.D.
465 Miller Avenue, Mill Valley, CA 94941 P(415) 380-7970 F(877) 992-3213

Authorization for Release of Medical Record Information

______________________________	______________________________
Patient Name	Date of Birth
______________________________	______________________________
Telephone	Social Security Number

Please **OBTAIN** information **FROM:**

______________________________	______________________________
Name of Provider/Clinic/Organization	Street address
______________________________	______________________________
City, State, Zip code	Phone# / Fax#

Please **SEND** information **TO:**

__**Josefa Rangel, M.D.** __________________	**465 Miller Avenue**____________
Name of Provider/Clinic/Organization	Street address
__**Mill Valley, CA 94941**________________	_**p(415) 380-7970 / f(877) 992-3213**
City, State, Zip code	Phone# / Fax#

I authorize the following information to be disclosed:

☐Entire medical record ☐Immunization record ☐Lab & imaging results

☐Consultation reports ☐Operative reports & findings ☐Medication records

☐Other (describe):____

☐Restrictions and/or exclusions (if any):__________________________________

This information is being disclosed for the purpose of:

☐Continuing care ☐At my request ☐Insurance ☐Legal ☐Job ☐School

☐Other (describe):____

This authorization will expire ninety (90) days from the signature date. I understand that this authorization may be revoked in writing at any time, except to the extent that Dr. Rangel, MD has relied upon it. I understand that Dr. Rangel, MD will continue to provide care, even if I do not authorize this release.

______________________________	______________________________
Signature of patient	Date
______________________________	______________________________
Signature of parent or guardian (if minor patient)	Date