FAMILY MEDICINE ASSOCIATES OF NORTHRIDGE, INC.
18350 ROSCOE BLVD., SUITE 600
NORTHRIDGE, CALIFORNIA 91325
TELE: (818) 727-1515 FAX: (818) 727-7997

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize the release and/or disclosure of ALL medical information from:

FAMILY MEDICINE ASSOCIATES OF NORTHRIDGE
18350 ROSCOE BLVD., SUITE 600
NORTHRIDGE, CA 91325
(818) 727-1515

TO:

____
____
____
TELE: (   )   - ____________
FAX: (   )   - ____________

Release and/or disclose records and information regarding:

PATIENT NAME: ______________________________
ADDRESS: ______________________________
____
PHONE #: ______________________________

PATIENT D.O.B.: ______/______/______________

______________________________ **DATE:** ____________________
SIGNATURE OF PATIENT
OR LEGAL GUARDIAN

****This authorization will expire 12 months from the date signed.***

******PLEASE NOTE THAT WE CHARGE A FEE TO THE PATIENT OR ENTITY REQUESTING COPIES OF RECORDS BASED ON THE SIZE AND ACCESSABILITY OF CHART RECORDS.******