PATIENT AUTHORIZATION TO RELEASE RECORDS

Name of Patient: _____ DOB: _____

For Transfer of Records From:

Name of Facility: _____

Address: _____

_____

Phone: _____ Fax: _____

To:

Humphrey Lu, MD

640A Purissima Street

Half Moon Bay, CA. 94019

T: (650) 560-9137 F: (650) 560-9138

I hereby authorize transfer of information for purposes of medical care and/or consultation:

All Records OR Limited to the following: _____

Signature of Parent/Guardian: _____

Printed Name of Parent/Gaurdian: _____

Date: _____

Updated December 2015