PATIENT AUTHORIZATION TO RELEASE RECORDS

Name of Patient: _____ DOB: _____

For Transfer of Records From:

Name of Facility: _____

Address: _____

_____

Phone: _____ Fax: _____

To: Humphrey Lu, M.D. 319 Church Street, Half Moon Bay, CA 94019

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/Guardian: _____

Date: _____

HUMPHREY LU, M.D. 319 CHURCH STREET 650-560-9137
www.HMBabies.com HALF MOON BAY, CA 94019 fax 650-560-9138