

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.
640-A Purissima 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: _____