

Noel T. Chiu, M.D., AMC

James A. Jewell, P.A.

3701 Lone Tree Way, Ste. 6 • Antioch, CA 94509 • 925-754-6767 • Fax 925-754-0137

Medical Records Release

From: _____

To: _____

I request a copy or summary of the following medical records:

- | | |
|--|---|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Biopsy Report(s) |
| <input type="checkbox"/> Lab Report(s) | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Medication Allergies | <input type="checkbox"/> Allergy Test/Treatment |
| <input type="checkbox"/> Surgical Procedures | <input type="checkbox"/> Other _____ |

Please check one:

- For dates of service from ___/___/___ to ___/___/___
- For all dates of service

Additional comments: _____

I understand that there may be a reasonable medical records copying fee as permissible by state law.

PATIENT, PARENT/GUARDIAN SIGNATURE

___/___/___
DATE