Innate
MEDICINE

Josefa M. Rangel, M.D.

Authorization for Release of Medical Record Information

Patient Name _____ Date of Birth _____

Telephone _____ Social Security Number _____

Please **OBTAIN** information **FROM:**

Name of Provider/Clinic/Organization _____ Street address _____

City, _____ State, _____ Zip code _____ Phone# / Fax# _____

Please **SEND** information **TO:**

__ **Josefa Rangel, M.D.** _____.
Name of Provider/Clinic/Organization

201 Miller Avenue_____
Street address

Mill Valley, CA 94941 _____
City, State, Zip code

f(415) 408-6409_____
Fax#

I authorize the following information to be disclosed:

☐Entire medical record ☐Immunization record ☐Lab & imaging results

☐Consultation reports ☐Operative reports & findings ☐Medication records

☐Other (describe):_____

☐Restrictions and/or exclusions (if any):_____

This information is being disclosed for the purpose of:

☐Continuing care ☐At my request ☐Insurance ☐Legal ☐Job ☐School

☐Other (describe):_____

This authorization will expire ninety (90) days from the signature date. I understand that this authorization may be revoked in writing at any time, except to the extent that Dr. Rangel, MD has relied upon it. I understand that Dr. Rangel, MD will continue to provide care, even if I do not authorize this release.

Signature of patient _____ Date _____

Signature of parent or guardian (if minor patient) _____ Date _____