RICHARD K. ELIA, M.D.
FAMILY MEDICINE
5375 North Palm
Fresno, CA 93704

Name of Patient: _____

Information to be released to: **Richard K. Elia, M.D.**
5375 North Palm **Phone: 559-435-3542**
Fresno, California 93704 **Fax: 559-431-2457**

INFORMATION TO BE RELEASED FROM:

NAME: _____

ADDRESS: _____

_____

PHONE/FAX: _____

*****All allowable fees for copies must be paid prior to receiving records*****

PLEASE SEND THE FOLLOWING:

√ **History/Physical**	√ **X-ray Reports**	√ **EKG/Treadmill**
√ **Lab Reports**	√ **Consultations**	√ **Medication List**

I understand that this authorization:

(1). Prohibits further use or disclosure of the information being released beyond the specific limits of this consent.
(2). Includes all medical records or other information regarding my treatment, hospitalization, and/or outpatient care of my condition.
(3). Expires six months from the date of signature.
(4). This authorization may be revoked at any time at my request.
(5). I understand that I have a right to receive a copy of this authorization.

_____ _____
Signature of Patient or Legal Guardian Date