

## MEDICAL INFORMATION TRANSFER REQUEST:

PLEASE RETURN RECORDS TO:

ERIC M. MUNRO, MD, M.P.H, INTERNAL MEDICINE  
3500 LOMITA BLVD., SUITE 100  
TORRANCE, CA 90505  
TELEPHONE: 310-784-0300  
FAX: 310-784-0303

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I request and authorize the following entity to release a copy of the health care record of the patient named above:

Name:  South Bay Family Medical Group  
 Other \_\_\_\_\_

Please send all requested information to:

ERIC M. MUNRO, M.D., M.P.H, INTERNAL MEDICINE  
3500 LOMITA BLVD., SUITE 100  
TORRANCE, CA 90505  
TELEPHONE: (310)784-0300  
FAX: (310) 784-0303

I hereby request transfer of all medical records from the above stated entity to Eric M. Munro, M.D., M.P.H.

\_\_\_\_\_  
*Signature of patient or patient's authorized representative*

\_\_\_\_\_  
*Date signed*

\_\_\_\_\_  
*Relationship to the patient if signed by anyone other than the patient*

\*Parent or authorized representative may sign for a minor child.