AUTHORIZATION TO TRANSFER MEDICAL RECORDS

_____

Patient Name: _____ Date of Birth: _____

By signing this authorization, I approve and request the release of the medical records for the patient named above.

From:

Office Name: _____ *or* ☐ Eric M. Munro, MD, MPH

Doctor's Name: _____

Address: _____

Phone: _____

Fax: _____

To:

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

or

Office Name: _____
Doctor's Name: _____
Address: _____
Phone: _____
Fax: _____

Please transfer and disclose all medical records, reports and associated health information.

_____ _____

Signature of patient or patient's authorized representative *Date signed*

_____

Relationship to patient if signed by authorized representative

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand I do not have to sign this authorization in order to get health care benefits. I understand that I have the right to revoke this authorization at any time in writing, except to the extent that the medical provider named above or Eric Michael Munro MD Inc has acted in reliance upon the authorization.