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Authorization for Release of Protected Health Information

Patient's Name: _____ **DOB:** _____

Address: _____

City: _____ **CA** _____ **ZIP** _____

I hereby authorize:

☐ Takashi Yoshida MD, Inc.
2490 Hospital Dr #103
Mountain View, CA 94040

☐ Provider _____
Address: _____
City; _____

To release information to:

☐ Takashi Yoshida MD, Inc.
2490 Hospital Dr #103
Mountain View, CA 94040

☐ Provider _____
Address: _____
City; _____

Information to be Released:

☐ All Records ☐ Immunizations ☐ Procedure Reports ☐ ER Reports
☐ Laboratory reports ☐ X-Ray Reports ☐ Consultations ☐ Other _____

_____ _____
Signature Print Name

_____ Phone# _____
Relationship to Patient

This authorization for Takashi Yoshida MD, Inc., to release or information being requested of you to comply with the terms of Confidentiality of Medical Information Act, Section 56 of California Civil Code.

OFFICE USE ONLY

Requested Medical Records: ( )Mailed ( ) Faxed ( )Picked up By _____

Date: _____ **Time:** _____ **am/pm By:** _____