Yun-Ching Chen, MD
P.O. Box 1105
Capitola, CA 95010

831-462-6013 (TEL.)
831-465-9519 (FAX)

RELEASE OF MEDICAL RECORDS

___ I _____(patient's full name), request that a copy of my confidential medical records as stated below, be sent to Yun-Ching Chen, MD. **PLEASE USE US POSTAL MAIL IF OVER 15 PAGES RECORDS TOTAL**.

___ Request addressed to: _____(Provider)
_____(Address)
_____(Fax #)

___ I_____(patient's full name) request that Dr. Chen release a copy of my confidential medical records as stated below, to be sent to:

_____(Person receiving medical records)
_____(Mailing address or FAX number)
_____
_____

Records to be released:

___All laboratory test results for the past _____years

___All chart notes for the past _____years

___ALL medical records for the past _____years

___Specific biopsy or surgical reports:

___Specific radiology reports:

_____Patient's full name

_____Date of birth

_____Signature of patient

_____Date of signature

_____Expiration date of this release