The Holman Group
Medical Record Release Form

Notice:
Unless otherwise required by law, The Holman Group will not release any medical information on any of its enrollee/patients unless the information below has been completely filled out and signed by both the party requesting the medical record information and the enrollee/patient, or the enrollee's/patient's authorized agent, and delivered with the appropriate copying service fee to The Holman Group, 21050 Vanowen Street, Canoga Park, California 91303.

The undersigned authorizes the release of the medical information described below concerning _____ *(name of enrollee/patient)*, born _____ *(date)*, by The Holman Group, to _____.*(name of entity* to *receive information).*

This authorization is limited to the following type of ***specific*** information:

_____
_____
_____

This authorization is limited to the following ***specific uses*** of information released:

_____
_____

This authorization shall remain valid only until _____ (date) at which time the person or entity requesting the information will destroy the information and all copies in their control, or will return the information and all copies of it to The Holman Group,

_____ (name Of Patient) has the right to receive a true copy of this authorization. By placing his/her initials to the left of this clause on the original authorization, the undersigned acknowledges that a true copy of this authorization has been received.

Dated: _____

Signature: _____ *(enrollee/patient or their authorized agent)*

Printed Name: _____