Santa Monica Bay Physicians

A medical Group. Incorporated

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Malibu Office
23805 Stuart Ranch Road, Suite 230
Malibu, CA 90265
(310) 456-0333
fax (310) 317-7003

Montana Office
804 Seventh Street
Santa Monica, CA 90403
(310) 395-5588
fax (310) 395-6313

Ocean Park Office
2701 Ocean Park Blvd.
Suite 130
Santa Monica, CA 90405
(310) 450-1200
fax (310) 450-8830

Palisades Office
910 Via de la Paz
Suite 203
Pacific Palisades, CA 90272
(310) 459-2363
fax (310) 459-1517

Plaza Office
1260 15th Street
Suite 1410
Santa Monica. CA 90404
(310) 451-8851

Wilshire Office
2424 Wilshire Blvd.
Santa Monica, CA 90403
(310) 828-4530
tax (310) 453-4613

I hereby give Santa Monica Bay Physicians permission to copy and release my medical records, including any records relating to alcohol/drug history, HIV results, and/or psychological diagnoses, with the following exceptions:

DO NOT RELEASE THE FOLLOWING:

- ☐ Alcohol and/or drug abuse treatment history
- ☐ HIV results
- ☐ Psychiatric consultations
- ☐ Other ___________________

Please release my records as follows:

☐ I will pick them up on ________ at/after ________
(Date) (Time)

☐ ______________________________ who is my ______________________
(Name) (State relationship)

will pick them up on ____________ at/after ____________
(Date) (Time)

☐ Please mail my records to:

Name: ________________________________

Address: ________________________________

____

____

Phone #: ________________

____ ______________
PATIENT NAME (PRINT) Date of Birth

____ ______________
PATIENT SIGNATURE (or parent/guardian) Date

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