**Medical Records Release Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary or narrative of my protected health information to the physician(s)/person/facility/entity listed below.

The information you may release are as follows: complete medical records, care plan, pathology reports, Hospital reports, history & physical, lab reports, treatment record, medication record, prescription history, progress notes, radiology reports, and operative reports.

Release my protected health information to the following:

1. Richard David Griffith, M.D.
2. Kevin Parzych, M.D.
3. Wilshire Connected Care, Inc.

Patient/POA Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_