AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize:

Clinic/Doctor: _____________________________ Clinic/Doctor: _____________________________

Phone: ___________________________________ Phone: ___________________________________

Fax: _____________________________________ Fax: _____________________________________

to release medical records on the following patient:

Patient Name: _____________________________

Address: __________________________________

Phone: ____________________________________

Date of Birth: ______________________________

Type of records requested:

☐ Imaging: ____

☐ Pap / Mammogram

☐ Progress Notes

☐ Hospital Discharge Summaries

☐ Surgical Notes

☐ Vaccination History

☐ Other: ____

Records are to be transferred to:

Dr. Meg Hennessay
Hennessay Medical Direct Primary Care
3655 Lomita Blvd., Ste. 307
Torrance, CA 90505
Office 424-235-5235/**Fax 424-389-7252**

____
Signature

____
Printed Name / Date