STEVEN MACHTINGER, M.D. & ASSOCIATES, INC.

Consultants in Allergy, Asthma and Immunology of Children and Adults
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MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name _____ Account #_____

Birthdate _____ Social Security # _____

When you complete and sign this form you authorize Steven Machtinger, MD & Associates to release some or all of your medical information necessary to provide you with optimal medical care. Signing this form is required by law in compliance with the CONFIDENTIALITY OF MEDICAL INFORMATION ACT, Section 56 et seq. of the CALIFORNIA PENAL CODE.

AUTHORIZATION: I hereby authorize and request that:

STEVEN MACHTINGER, MD & ASSOCIATES, INC.
100 South Ellsworth Avenue, Suite 707, San Mateo, CA 94401

Provide information to a designee or representative of:

Name _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

This information is required for:

_____

_____

Type of information requested (notes, laboratory or X-ray results, dates of service, etc.)

_____

_____

Any information not to be released (Check none, if none). [ ] None

_____

_____

This authorization is effective immediately and shall remain in effect until: _____
You may revoke this authorization by sending us a signed letter. You cannot use email or a mobile phone message for this purpose. Your request will be processed on the next normal business day.

Signature _____ **Date** _____

If not patient, relationship [ ] Spouse [ ] Parent [ ] Guardian [ ] Other _____

[Templates/medrelease210422rev.]