PRIMARY HEALTH PARTNERS
3601 VISTA WAY, SUITE 201
OCEANSIDE, CA 92056

MEDICAL RECORDS REQUEST

I Hereby Authorize:	**To Furnish To:**
☐ ______________________	☐ **Michelle Gonzales, MD**
P ______________________	**P** 760.639.1204
F ______________________	**F** 760.630.1252

Please Send: ____

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I understand that general records may contain Doctor's Office Notes, Emergency Room Reports, X-ray/Lab Reports, Medical and/or Mental Conditions, Alcohol and Drug Conditions, HIV Testing and other sensitive information.

I understand that I may formally request exclusion of any sensitive information.

Exclude: ____

You have a right to have a copy of this authorization. This consent shall remain valid for 6 months from the date of signature. This authorization may be revoked in writing to the above address.

Name: ______________________________ DOB: __________

Address: ____

City: ____________________ State: __________ Zip: __________

Signature: ______________________________ Date: __________

Relationship to Patient (circle): Self / Parent / Guardian / Legal Representative