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

MEDICAL RECORDS REQUEST

I Hereby Authorize:	**To Furnish To:**
☐ _____	☐ **Wilson Liu, MD**
P _____	**P** 760.529.9503
F _____	**F** 760.630.1252

Please Send: _____

_____

_____

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