Dina Massry, M.D.
Jeffrey Eaton, M.D.
Jennifer Eastlack, M.D.

DEL MAR M.E.D.
A Medical Corporation

Authorization: I authorize the release of information pertaining to medical history, mental or physical condition, services rendered, or treatment, as described below for:

Name of Patient: ______________________________ **Date of Birth:** _____/____/_____

Social Security Number: ______-_____-______ **Telephone** (   ) _______-__________

Record Holder:____

____
Street Address City State Zip

(   ) ________________________________ (   ) ________________________
Phone Fax

Records May Be Released To: ____

____
Street Address City State Zip

(   )________________________________ (   ) ________________________
Phone Fax

DATE OF SERVICE: From: ________/________/________ To: ________/________/________

Type of Information: This authorization is limited to the following medical records and type of information:

□ Discharge Summary □ Pathology Report □ Pathology Slides □ Progress Notes
□ History/Physical Exam □ Laboratory Tests □ Consultation reports □ X-ray reports
□ Operative/Procedure Reports □ Photographs, videotapes, digital or other images
□ Emergency Department Reports □Other (please specify):______________________

Use of Information: The requestor may use the medical records and type of information authorized only for the following purposes:

□ Continuing Care □ Second Opinion □ Personal □ Insurance Claim

□Other (Please specify): ____

Printed Name:____ **Date**: _______________

Patient/Patient's Parent or Guardian Signature: ___________________________________

I hereby authorize release of all information as stated above.

12395 El Camino Real, Suite 200, San Diego, CA 92130 | P 858.481.3376 | F 858.755.5947
delmarmed.com