Dina Massry, M.D.
Jeffrey Eaton, M.D.
Jennifer Eastlack, M.D.
Jenna Borok, 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): _____

Fee for Printed Medical Records greater than 5 pages. I acknowledge and agree to pay a fee of 25 cents per page plus a $15 service fee for requests greater than 20 pages.

Printed Name:_____**Date**: _____

Patient/Patient's Parent or Guardian Signature: _____

I hereby authorize release of all information as stated above.