

# Santa Monica Bay Physicians

A medical Group, Incorporated

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby give Santa Monica Bay Physicians permission to copy and release my medical records, including any records relating to alcohol/drug history, HIV results, and/or psychological diagnoses, with the following exceptions:

### DO NOT RELEASE THE FOLLOWING:

- Alcohol and/or drug abuse treatment history
- HIV results
- Psychiatric consultations
- Other \_\_\_\_\_

### Please release my records as follows:

- I will pick them up on \_\_\_\_\_ at/after \_\_\_\_\_  
(Date) (Time)
- \_\_\_\_\_ who is my \_\_\_\_\_  
(Name) (State relationship)  
will pick them up on \_\_\_\_\_ at/after \_\_\_\_\_  
(Date) (Time)

- Please mail my records to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

Malibu Office  
23805 Stuart Ranch  
Road, Suite 230  
Malibu, CA  
90265  
(310) 456-0333  
fax (310) 317-7003

Montana Office  
804 Seventh Street  
Santa Monica, CA  
90403  
(310) 395-5588  
fax (310) 395-6313

Ocean Park Office  
2701 Ocean Park  
Blvd.  
Suite 130  
Santa Monica, CA  
90405  
(310) 450-1200  
fax (310) 450-8830

Palisades Office  
910 Via de la Paz  
Suite 203  
Pacific Palisades, CA  
90272  
(310) 459-2363  
fax (310) 459-1517

Plaza Office  
1260 15th Street  
Suite 1410  
Santa Monica, CA  
90404  
(310) 451-8851

Wilshire Office  
2424 Wilshire Blvd.  
Santa Monica, CA  
90403  
(310) 828-4530  
fax (310) 453-4613

\_\_\_\_\_  
PATIENT NAME (PRINT)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
PATIENT SIGNATURE (or parent/guardian)

\_\_\_\_\_  
Date