TRI-VALLEY
MEDICAL CENTER, INC.

RELEASE OF MEDICAL RECORD

OFFICE NUMBER: (925) 866-8800 OFFICE FAX: (925) 866-8802

DATE OF REQUEST: _____

NAME_____ DATE OF BIRTH_____

STREET ADDRESS_____

CITY/STATE/ZIP_____

INFORMATION TO BE RELEASED: (PLEASE CHECK ONE OF THE FOLLOWING)

_____ENTIRE CHART _____EXAM/EVALUATION _____TREATMENT

_____DIAGNOSIS _____HOSPITALIZATION

_____OTHER (PLEASE SPECIFY)_____

DATE OF TREATMENT:_____

PURPOSE OF DISCLOSURE (WHY ARE RECORDS

REQUESTED)_____

I HEREBY REQUEST THAT MEDICAL RECORDS BE RELEASED TO:

TRI-VALLEY MEDICAL CENTER, INC

DR. JATINDER MARWAHA, MD / DR. DIMPLE MARWAHA,DPM (PLEASE CIRCLE ONE OR BOTH)

1081 MARKET PLACE, STE 200

SAN RAMON, CALIFORNIA 94583

FROM:

CLINIC/PHYSICIAN ADDRESS CITY/STATE/ZIP

WAIVER OF LIABILITY:

I waive all rights and privileges allowed by law relating to disclosure of confidential information, defamation, invasion of rights of privacy and release the above person(s) or agency(ies) from legal responsibility of liability arising from the request for medical records

Note: The original copy is in the patient medial record and may be reviewed upon request. This is a duplication of the original, and unless otherwise noted, is identical to the original.

I understand that this release may be revoked at any time, but such revocation may not be applied retroactively once such information has been released in good faith.

NOTICE: The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS.

PATIENT OR AUTHORIZED SIGNATURE RELATION TO THE PATIENT(IF NOT PATIENT) DATE SIGNED.