

**Pacific Frontier Medical, Inc.**  
**Patient Consent to Release Medical Information**

This form allows other medical providers to release your medical information to Pacific Frontier Medical, Inc. in the event you require us to have your medical historical information.

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

Other Names Used: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Medical Record Number (If applicable): \_\_\_\_\_  
(i.e. Kaiser member #, hospital #, ect...)

I HEARBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL RECORDS  
OBTAINED IN THE COURSE OF MY DIAGNOSIS AND TREATMENT INCLUDING  
SUMMARIES, LABORATORY AND DIAGNOSTIC STUDIES, MEDICATIONS AND  
IMMUNIZATIONS TO:

Pacific Frontier Medical, Inc.  
Dr. Steven J. Harris, MD  
1098 Foster City Blvd. Suite 305  
Foster City, CA 94404  
Phone: 650-474-2130  
Fax: 650-445-0912

A COPY OF THIS RELEASE IS AS EFFECTTIVE AS THE ORIGINAL

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*This form is valid from date signed and up to five years after date signed.