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 HEREBY 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 EFFECTIVE AS THE ORIGINAL

Patient Signature:_____ Date:_____

Parent Signature:_____ Date:_____

Parent Signature:_____ Date:_____