



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____

Address: _____

Telephone/Fax: _____

I hereby authorize you to release to Jackson Medical Group:

Santa Barbara Office
517 W. Junipero St.
Santa Barbara, CA 93105
(805) 682-8844 FAX (805) 682-6499

Carpinteria Office
5565 Carpinteria Ave., Ste. 4
Carpinteria, CA 93013
(805) 684-4119 FAX (805) 566-2181

Goleta Office
334 S. Patterson Ave., Ste. 120
Goleta, CA 93111
(805) 683-0055 FAX (805) 683-0149

Attention:

- Douglas R. Jackson, M.D.
- Douglas Cummings, M.D.
- W. Nicol Guddal, M.D.
- Elizabeth J. Cardinale, M.D.
- Charles S. Nowak, D.O.
- Nancy Warner, FNP
- Karen Hanna Arndt, PA-C
- Amoret E. P. Lifquist, PA-C

The complete medical records in your possession concerning my history, physical examination, x-rays, diagnostic and laboratory data subject to the following limitations:

None _____

I hereby release Dr. Jackson from any/all legal liability that may arise from the release of this information to the party above.

A photocopy of this authorization shall be as valid as the original. This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken, and if not earlier revoked, this consent shall become invalid six months from the date of the signature.

I understand that I have the right to reserve a copy of this authorization upon my request.

Copy requested and received: No Yes

Patient's Name (please print): _____

Patient's Date of Birth: _____ **Social Security Number:** _____

SIGNATURE: _____ **Date:** _____

If signed by other than patient, please indicate relationship: _____

Witness: _____

I hereby authorize that all psychiatric/mental health substance abuse AIDS treatment, testing and diagnostic records be release to the above:

Signature

Date