Patient Release of Medical Records Form
(Please Print or Type)

Patient's Name:_____________________ request and give my permission to release my Medical Records for the time period dating from_____________ to ____________ from the following Medical Clinic:

M.M.P.E. Medical Clinic
Dr. R. Stephen Ellis, M.D.
450 Sutter St. , Suite 1415
San Francisco, CA 94108
Office Phone (415) 681-0823

The Medical Records as listed above are to be released to:

Name:____

Address:____

City_______________________State___________zip_____

Phone Number:____________________________________

Fax Number:_______________________________________

Comments____

____

If Faxing or mailing the Release of Medical Records Form to the Medical Clinic, include a copy of a photo ID such as a State issued Driver's License, State Issued ID Card, or Passport.

Type of ID Presented:____________________ ID #___________________

______________________________	___________	______________
Printed Patient Name	**Date of Birth**	**Social Security #**

______________________________	______________________________
Patient’s Signature	**Today's Date**