Stacy L. Waneka, M.D.
Diplomate, American Board of Family Medicine

Dear Patient:

In order to ensure quality and continuity of care, I would like to obtain any medical records/information from your former or other current practitioner(s) that may be relevant to your care here. In order to facilitate this, I ask that you please fill out this form and either return it to my receptionist or forward it to the other practitioner(s) office.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I would like my records released from:

_____
(Name of past/other physician, clinic, facility)

_____
(Address)

_____
(City, State, Zip)

_____
(Phone number)

_____
(Fax number)

I hereby give permission for my medical records to be copied and released to:

Stacy L. Waneka, M.D.
881 Alma Real Drive, Suite 316
Pacific Palisades, CA 90272
Phone: (310) 454-1317
Fax: (310) 454-1709

Please release all of my records including and records relating to alcohol/drug history, HIV results, and/or psychological diagnoses, with the following exceptions:

- Alcohol and/or drug abuse treatment history
- HIV results
- Psychiatric consultations
- Other _____

_____ _____
PATIENT NAME (Print) Date of Birth

_____ _____
PATIENT (or parent/guardian) SIGNATURE Date