Alexis Alexandridis M.D.
BREAST & GENERAL SURGERY

REQUEST for Disclosure and Use of Protected Health Information

(Release of Medical Records)

I, _____
(print patient name, date of birth, phone number)

consent and authorize

_____

_____
(print name or facility, address, phone number, fax number)

to release the following records to Alexis Alexandridis, MD at 246 Perkins Street, Sonoma CA 95476. Fax 844-581-1700:

- O *ALL* medical records
- O Operative/procedure notes
- O Chart notes, progress notes from medical office
- O Pathology reports
- O Lab reports, EKGs
- O Imaging reports
- O Other: _____

If records are released the following information may be included unless you indicated here to withhold. *Do not release*:

- O Mental health or psychiatric care records
- O HIV testing results
- O Alcohol/substance abuse treatment
- O Other Please specify: _____

From the service dates: O All dates of service. O Limited dates: _____

I understand this authorization may be revoked in writing at any time unless it has already been acted upon. To revoke, I must send a written request to Alexis Alexandridis, MD at 246 Perkins Street, Sonoma CA 95476.

This authorization will expire in ONE YEAR unless noted otherwise here:
Date of expiration: _____

Signature of Patient or Authorized Representative:

_____

Signature Today's Date Relationship to Patient