Elizabeth B. Fraze, M.D.

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Phone 650.853.1353 Fax 650.853.0560

Release of Information

I hereby authorize: Elizabeth B. Fraze, M.D.

To: Obtain information from: Name: _____

Address: _____

_____

_____

Telephone: _____

The information requested or authorized for release or exchange pertains to:

- ☐ All Medical records, including: Labs, Radiology, and Office Visits
- ☐ Labs
- ☐ Radiology

This authorization is valid for 1 calendar year. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my Medical Health evaluation or treatment.

_____ _____
Patients Name Date of Birth

_____ _____
Patients Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date