

**Authorization for Release of Medical Information**

1. Information requested from:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

2. Information to be sent to:

Irene Teper, M.D.  
165 Rowland Way  
Suite 201  
Novato, CA 94945-5009

Phone: (415) 897-3174

Fax: (415)892-9589

3. Patient's identifying information:

Patient's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

4. Specific medical records or reports requested:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Patient's or authorizing person's signature:

I hereby authorize the physician, medical practitioner, hospital, clinic or medically related facility shown in item 1 above to provide the physician shown in item 2 with any records, reports or other information regarding my medical condition or history,

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_