YOLANDA T. GRADY, M.D., INC.
13768 Roswell Avenue Suite 202
Chino, CA 91710
(909) 628-4205-Telephone
(909) 628-4875-Fax

MEDICAL RECORDS REQUEST

Patient's Name: _____

Date of Birth: _____ *Social Security #_____*

Phone # _____ *Cell #_____*

I hereby request Medical Records FROM:

Doctor Name & Specialty *_____Specialty: _____*

Street Address: *_____*

City, State & Zip *_____*

Telephone Number:_____ *Fax Number _____*

Reason for Request:_____

Requesting: *_____Entire Record* *_____Specific Information_____*

***** I give special permission to release information on the following: (Initial each line below if your give permission)***

_____Substance Abuse *_____Psychiatric Mental Health Information* *_____HIV/ AIDS information*

To furnish to : ***YOLANDA T GRADY, M.D.***
Address: ***13768 Roswell Avenue, Suite 202***
Chino, CA 91710

Restrictions: *I understand the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.*
Additional Copy: *I further understand that I have the right to receive a copy of this authorization upon my request.*

Signed: _____, _____DATE:_____
(If not Patient, State Relationship)