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

MEDICAL RECORDS REQUEST

Patient's Name:_____

Date of Birth:_____ Social Security #_____

Phone # _____ Cell #_____

I hereby request my medical records to be sent:

FROM: ***YOLANDA T GRADY, M.D. Inc.***
Address: ***13768 Roswell Avenue, Suite 202***
Chino, CA 91710

TO: _____

_____

_____

Reason for Request:_____

Requesting: _____Entire Record _____Specific Information_____

****** I give special permission to release any information regarding: (Initial each line below if your grant permission to obtain records)

_____Substance Abuse _____Psychiatric Mental Health Information _____HIV/ AIDS information

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)