PARTNERS:
James A. Cisco, MD
Sarah G. Cueva, MD
Margaret M. Miller, MD MPH

REQUEST FOR MEDICAL RECORDS

I authorize: ____

To release medical records of: ____

Name Date of Birth

Including:

- ☐ Medical evaluations
- ☐ Vaccination history
- ☐ Growth records
- ☐ Radiology reports
- ☐ Laboratory evaluation

Fax To: 650-321-9556

☐ James Cisco, MD ☐ Sarah Cueva, MD ☐ Margaret Miller, MD

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Name of individual requesting records: ______________________________

Relationship to patient: ____

Signature: ____Date: ________

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