



Kimberly Cockerham MD, FACS
Plastics-Orbit-Neuro-Ophthalmology

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

1. I hereby authorize _____ to disclose the following information to the office of Dr. Kimberly Cockerham from the health records of:

Patient Name: _____ D.O.B: _____

Facility Address: _____ Phone: _____

Covering the period(s) of healthcare:

From (date) _____ to (date) _____

2. Information to disclose:

- | | |
|---|--|
| <input type="checkbox"/> Complete health record | <input type="checkbox"/> Outpatient/Clinical Notes |
| <input type="checkbox"/> Inpatient Progress Note(s) | <input type="checkbox"/> Pathology report |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Laboratory Test Reports |
| <input type="checkbox"/> Radiology (X-Ray) Reports | <input type="checkbox"/> Visual Field/HRT Tests |
| <input type="checkbox"/> Other (please specify) _____ | |

3. This information will be disclosed to the office of Dr. Kimberly Cockerham.
Please: Mail to Fax to

762 Altos Oaks Drive Ste 2 (650) 559-9151
Los Altos, Ca 94024
(650) 559-9150

Please transfer requested information by this date _____

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

Signed: _____ (patient or legal guardian) Date: _____

If legal guardian, please state relationship to patient: