Cindy Alberts Carson, MD
960 E. Green St. • Suite 104
Pasadena, CA 91106
(626) 793-9353
(626) 793-9315

Authorization to Transfer Medical Records

I ____ hereby authorize

____, MD to furnish the

following medical information about the undersigned to Dr. Cindy Carson. Any and all information may be released, including but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and alcohol abuse records, and HIV test results, if any.

1. Any laboratory results from the previous 12 months.
2. Any imaging results from the previous 5 years.
3. Records of any screening or diagnostic tests (e.g. colonoscopy, DEXA, mammograms, Pap smears, biopsies, EKGs)
4. Records of any consultations from the previous 5 years.
5. A recent progress note, if available.

I understand that I may be charged a reasonable fee for photocopying and/or transmittal of these records.

This request authorization is effective for 30 days from the date it is signed.

____ Date ________________

Patient