

**Karina Garcia, MD**  
*Internal Medicine*  
229 W. Pueblo St.  
Santa Barbara, CA 93105  
Phone: (805) 898-0500 Fax: (805) 617-0904

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**Medical Records Release To Our Facility**

**Patient Information:**

Name: \_\_\_\_\_

Date of Birth
/  /

**To Whom It May Concern:**

**Please release my medical records to:**

**Dr. Karina Garcia, MD Internal Medicine**  
229 W. Pueblo St, Santa Barbara CA 93105  
Phone: (805) 898-0500 Fax: (805) 617-0904

**Information to be disclosed:** This authorization permits the provider to disclose the following medical records: (check one of the following)

All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including, without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

All of my health information described except for the following:

Only the following records or types of health information:

**\*\*If medical records are over 10 pages long, please mail\*\***

**\*\*Patient accepts responsibility for payment of copying services\*\***

**Medical Practice/Doctor Information:**

**From whom I am requesting my records be released:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_