

# RECORD REQUEST

*Please provide the following information & mail directly. It is important that we receive your child(s) records before their visit:*

To: \_\_\_\_\_ Member # for Kaiser Patients: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (Circle doctors name & office address below or Kaiser may delay processing)

(Provider or facility name , address & phone #)

Please release medical records concerning: \_\_\_\_\_

Birthdate: \_\_\_\_\_, for continuity of care to:

*William E. Rhea, M.D., Inc.*  
*Richard L. Oken, M.D., Inc.*  
*Myles B. Abbott, M.D., Inc.*  
*Mary D. Jones, M.D., Inc.*  
*Marcia E. Charles-Mo, M.D.*  
*Sarah Cahn Handelsman, M.D.*  
*Tracy Evans-Ramsey, M.D.*  
*Juliana L. Damon, M.D.*  
*Christina S. Vo, M.D.*  
*Jennifer A. Miller, M.D.*

2999 Regent St., #325  
Berkeley, CA 94705

96 Davis Rd., #2  
Orinda, CA 94563

925 438-1100

\_\_\_\_\_  
Signature Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Witness

\_\_\_\_\_  
Date

This authorization to remain in effect for one year from the date indicated above, or unless revoked in writing by the parent or guardian.