Raincross Medical Group, Inc.
The Cure For The Common Practice

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

I HEREBY AUTHORIZE: _____
Doctor or Facility

_____ _____ _____ _____
Street Address *City* *State* *Zip Code*

_____ _____
Phone *Fax*

PURPOSE
Continued patient care and treatment.

RELEASE THE FOLLOWING INFORMATION:

_____ All health information pertaining to my medical history, mental or physical condition and treatment received

_____ Only the following records or types of health information:

_____

RELEASE THE ABOVE INFORMATION TO:

Raincross Medical Group
4646 Brockton Ave
Riverside, CA 92506
Phone: (951) 774 - 2800

Physician Office Faxes:
Betina Greer M.D. 951-774-2945
Carl Knopke M.D. 951-231-1361
Yanjapriya Kunaseelan M.D. 951-774-2874
Daniel Solis M.D. 951-774-2955

SIGNATURE: _____
Patient/Legal Representative

DATE: _____ **TIME:** _____ ☐**AM** ☐**PM**

If signed by a person other than the patient, indicate relationship: _____

Print name: _____
Legal Representative