



1350 Norris Road
Bakersfield, California 93308-2231

AUTHORIZATION TO RELEASE INFORMATION
FROM THE MEDICAL RECORD

Case Number: _____

Patient's Name: _____ Unit Number: _____
Last First Middle

Address: _____ State: _____ Zip Code: _____

Date of Birth: _____ Mother's Maiden Name: _____ SSN: _____

I, the undersigned, hereby authorize

1) _____, 2) _____
(Name of medical facility) (Name of medical facility)

3) _____, 4) _____
(Name of medical facility) (Name of medical facility)

to provide from the patient's medical record information relative to the assault, which occurred on or
about _____, for which the victim received treatment, to the Kern
(date)

County Sheriff's Office for the purpose of pursuing a criminal investigation against the suspect(s).

The information requested is strictly limited to medical information and treatment received as a result

of injuries sustained in this assault. This authorization shall be valid until _____.
(date)

(Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional consent must be obtained for any proposed new use of the information or for its transfer to another person or entity. A copy of this authorization is valid as the original. I understand that I have the right to a copy of this form upon request.)

SIGNATURE:

Patient: _____ Date: _____

OR

Legal Representative: _____ Date: _____

Relationship to Patient: _____