MOLINA HEALTHCARE

Medical Release Form

Dear Member

Molina's goal is to do all we can to help you with your medical needs. If you or your family member has a new Primary Care Physician (PCP), your new PCP should have a copy of your medical records. Please fill out and sign this form. Please send the form to your old doctor.

To: _____

Old Doctor Phone#

_____

Address city State Zip

I APPROVE AND REQUEST THAT YOU SEND A COPY OF MY MEDICAL RECORDS TO

To:_____

New Molina PCP Phone#

_____

Address City State Zip

_____ _____

Your Name Patient or Legal Guardian Signature

_____ _____

Your address Relationship to Patient

_____ _____

City, State, Zip Date