MOLINA® HEALTHCARE

MEDICAL RELEASE FORM

Dear Member:

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

To: _____ _____
Previous Doctor Phone#

_____ _____ _____ _____
Address City State Zip

I HEARBY AUTHORIZE AND REQUEST THAT YOU SEND A COPY OF THE COMPLETE MEDICAL RECORD TO

To: _____ _____
Molina PCP Phone#

_____ _____ _____ _____
Address City State Zip

_____ _____
Your Name Patient or Legal Guardian Signature

_____ _____
Your address Relationship to Patient

_____ _____
City, State, Zip Date