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PATIENT RELEASE OF MEDICAL RECORDS FORM

Patient's Name _____ Today's date: _____

I request and give my permission to release my medical records for the time period dating

from _____ to _____ from the following medical clinic.

_____
(Name of clinic)

_____
(Address)

_____
(City) (State) (Zip code)

_____
(Fax number)

_____
(Comments)

Please send records to Dr. Scott Liang via fax (626) 628-0809 or mail to address below.

_____ _____
(Print patient's name) (DOB)

_____ _____
(Patient's signature) (Date)

This release of medical information is valid for one year after the date it was signed

revised 9-6-14