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Phone: 626-628-0808, Fax: 626-628-0809, www.drscottliang.com

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