



Scott Liang, M.D. Inc.

4153 E Live Oak Ave, Arcadia, CA 91006,
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 above.

(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
It is the policy of this medical practice is that we will adopt, maintain, and comply with our
notice of privacy practices, which shall be consistent with HIPAA and California law.