Authorization for Release of Medical Records

To:____

Physician's Name and Address

Patient's Name: _______________________________

First Name Family Name

Date of Birth: __________________

MM/DD/YYYY

I request that all medical records for the above named patient including but not limited to: chart notes, exam records, immunization records, diagnostic test results whether chemical, radiological or surgical, prescription records and specialist physicians' reports be sent to:

Erin C. Hamilton, M.D.
3440 Lomita Boulevard
Suite 429
Torrance, CA 90505
Phone: 310 326-8718 Facsimile: 310 326-2551

In accordance with the Business and Professions Code of the State of California upon receipt of this request you have 7 business days to send exact copies of the requested material or 14 business days to supply a detailed written summary of all care provided which includes all of the above information requested.

Signed: ____

Printed Name: ____

Relationship to Patient: _________________________________

Date Signed: _______________________________________

Witness Signature: ____

Printed Name: ____