Authorization to Release Medical Records

I, _____, hereby authorize my physician to release my medical records:

(Patient Name)

Requesting Records From

_____

(Name of Physician, Facility, or agency)

_____

(Address)

_____

(Telephone and Fax)

Records to be faxed to

Michelle Liske, MD

4340 Genesee Ave #207

San Diego, CA 92117

PH (858) 356-5600

F (858) 356-4965

Reason for request_____

_____ _____ _____ _____

(Date) (Patient Signature) (Date of Birth) (Phone Number)