Authorization for Release of Medical Records

To:_____
Physician's Name and Address

Patient's Name: _____

Date of Birth: _____

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:

Kristin Andrade, M.D.

20911 Earl Street, Suite 100

Torrance, CA 90503

Ph (310)214-2246, Fax (310)370-1590

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:_____ Date:_____

Printed Name:_____

Relationship to Patient: _____