



Medical Records Release Authorization

PLEASE ALLOW 7-10 BUSINESS DAYS TO PROCESS RECORDS

Patient First Name: _____ Last Name: _____

Date of Birth: _____ Date of Request: _____

Contact Number: _____

I, _____, hereby authorize release of my medical records to the following:

Name: _____

Address: _____

FAX: _____ PHONE: _____ EMAIL: _____

PREFERRED METHOD: (circle one)

EMAIL

FAX

IN-OFFICE PICK UP

MAILING ADDRESS

FOR OFFICE USE ONLY:

Description	Employee Name	Date of Completion
Release Form		
Payment Receipt - \$40.00		
Provider Approval Signature		
Billing Department		
Medical Record Department		
Release of Record		

16130 Ventura Blvd, Ste 120
Encino, CA, 91436

4353 Park Terrace Dr. Ste. 150
Westlake Village, CA 91361

1821 E. Daily Dr.
Camarillo, CA 93010