RECORDS RELEASE AUTHORIZATION

Name of Physician or Hospital: _____

Address: _____

Phone: _____ **Fax:** _____

I hereby authorize and request you to release to:

Jack M. Gindi M.D.

29525 Canwood Street, Suite # 209

Agoura Hills, CA 91301

Phone: (818)706-7773 Fax: (818)706-0390

Medical Records as Requested Below:

_____

_____

_____

The following individual has asked us to request his or her medical records to be released and forwarded to our office:

Patient's Name: _____ **Birth date:** _____

Patient's Address: _____

_____

Patient's Signature: _____ **Date:** _____