PACIFIC BRAIN TUMOR CENTER

AT PACIFIC NEUROSCIENCE INSTITUTE[SM]

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print)

Name:_____ DOB:_____

SSN:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Please Release My Records From

NAME:_____

TELEPHONE:_____

FAX:_____

TO OUR MAILING ADDRESS:

2125 ARIZONA AVE.
SANTA MONICA, CA 90404
PHONE 310-582-7450
FAX 310-582-7495

Please send these medical records no later than _____
(DATE)

Please release a copy of my records, including progress notes, operative notes, laboratory results, imaging reports (e.g., MRI and CT), diagnostic tests and pathology reports.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS.

SIGNATURE:_____ DATE:_____