PRESTIGE MEDICAL GROUP

RECORDS RELEASE FORM

From: _____

Address:_____

I hereby authorize and request the release of copies of the following information:

☐Complete ☐Medical Records ☐X-Rays

☐Laboratory Records ☐Procedure Reports ☐Other: _____

INCLUDING CURRENT AND PREVIOUS MEDICAL RECORDS FROM OTHER PRACTICES AND PRACTITIONERS, HOSPITALS, AND/OR CLINIC WHICH ARE A PART OF MY MEDICAL RECORDS.

To: Lamia L. Gabal, MD or Vera Trofimenko, MD 720 N. Tustin Ave., Ste 104, Santa Ana, CA 92705

Phone: 949.825.7650 Fax: 949.825.7648

This information has been released to you specifically with the consent of the patient or his/her authorized representative. It is strictly confidential and no further release or use of the information is authorized without the consent of the patient or authorized representative. I hereby release the facility from any Liability which may arise as a result of the use of the information contained in the records released.

Patient Name: _____ Date of Birth:_____

Social Security #: _____ Phone #: _____

Signature: _____ Date: _____

☐ Single Disclosure ☐ Continuing disclosure for 90 days ☐ Expiration Date: _____