Date:

Name: _____

Address: _____

_____

Release of medical records for _____

DOB: _____ Last 4 of SS#: _____

Authorization for release of medical records

Dear: _____

Please release my medical records for treatment rendered by you or under your supervision.

This information will be used to further assist in my medical care and should be faxed / emailed to:

PAIN AND HEALING INSTITUTE
Faial Lalani M.D. / Nadiv Samimi M.D.
1964 Westwood Blvd. Suite 435
Los Angeles, CA. 90025
Phone: (310) 856-9488
Fax: (310) 817-6402

My signature below bears authorization for this release.

Thank you.