MEDICAL RECORDS RELEASE AUTHORIZATION

Date:____

Patient:______________________________________

D.O.B:_______________________________________

S.S. ending in: XXX-XX-____________________

I, ____________________________________, request that my medical records from your office be forwarded to Steven A. Teitelbaum, MD. I give your office permission to send them via mail or facsimile, whichever Dr. Teitelbaum's office requests.

Please release all of my medical records from __________________to__________________

Steven A. Teitelbaum, MD, FACS
1301 20th Street, Suite 350
Santa Monica, CA 90404
(310) 315-1121 phone
(310) 315-9921 facsimile

____ Patient signature

__________________________ Date