REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
Name of Physician, Hospital or Facility

Address: _____
Address City State Zip Code

Phone: _____ Fax: _____

From: _____
Name of Patient

Re: **Request for Release of Medical Records**

I hereby request that my medical records, without limitations, including any HIV test results and/or treatment and any psychiatric records, be released to:

Pacific Thoracic Surgery, Inc.

24411 Health Center Drive, Suite 630

Laguna Beach, CA 92653

This authorization releases my medical records for the following designated purpose:

_____

This release is valid for 30 days after this date.

I understand that I am entitled to receive a copy of this release.

_____ _____
Signature of Patient or Legal Guardian Patient's Date of Birth

_____ _____
Print Patient's Name Date Signed

_____ _____
Print Name of Legal Guardian (relationship), if applicable Witness