

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____

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:

Tony Pham, M.D.
2500 Alton Pkwy #100
Irvine, CA 92606
Phone: 949-252-8822
Fax: 949-502-8872

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

*There is a \$25.00 charge for any medical records request (excluding doctor to doctor requests).