Records Release Authorization

To:_____
Address:_____
Phone #:_____Fax #:_____

I hereby authorize and request you to release to:

Stephanie Mandelman M.D.
1250 La Venta Dr. #101B
Westlake Village, CA 91361
Ph# 805-496-0880 Fax# 805-496-6670

All records in your possession concerning_____
_____

During the period from_____ to _____.

Name:_____Phone:_____
Address:_____
Signature:_____
Request Date:_____