TANGCHITNOB MD

MINIMALLY INVASIVE ROBOTIC SURGICAL GROUP FOR OBSTETRICS & GYNECOLOGY

REQUEST FOR MEDICAL RECORDS

TO: _____

_____

_____

RE: _____

_____

DOB: _____

RELEASE OF MEDICAL RECORDS: This form authorizes you to release copies of the above named patient's medical records including x-rays, laboratory, pathology, biopsies etc., to:

Dumrong Tangchitnob, M.D.

1135 S. Sunset Ave, Ste. 102
West Covina, Ca. 91790

Or via fax:
Fax: (626) 851-8822

Thank you for your assistance in this matter. If you have any questions, please contact our office at (626) 338-5377.

Patient's Name: _____ Date: _____

Patient's Signature: _____

CONSENT IS VALID FOR 3 MONTHS FROM THE DATE OF SIGNATURE