AUTHORIZATION TO RELEASE MEDICAL RECORDS

DATE: _____

I AUTHORIZE THE RELEASE OF MEDICAL RECORDS ON:

PATIENT'S NAME: _____

BIRTHDATE: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

FROM: _____

_____

_____

TO:

__ **STEPHEN KUNDELL, M.D.**
__ **LAILA NIAZI, M.D.,**
THOUSAND OAKS PEDIATRICS
1000 Newbury Road, Suite 200
Newbury Park, CA 91362
PHONE: 805-480-3730
FAX: 805-480-1951

INCLUDE:

__ **ALL MEDICAL RECORDS**

__ **MENTAL HEALTH RECORDS**

__ **SUBSTANCE ABUSE RECORDS**

__ **HIV/ STD TESTING RESULTS**

I understand that this may include information relating to mental or emotional diagnoses.

_____
SIGNATURE (PARENT OR GUARDIAN, OR PATIENT IF OVER 18 YRS)

NAME / RELATIONSHIP: _____