RECORDS RELEASE AUTHORIZATION

To: _____

(Doctor/Hospital)

_____

Address

_____

_____ _____

Phone Number Fax Number

I Herby Authorize and Request You to Release Medical Records to:

Michelle Aszterbaum, M.D.

1441 Avocado Ave. Suite 807
Newport Beach, CA 92660

P. (949) 525-0700

Please include completed medical history records in your possession concerning my illness and/or treatment during the period

FROM _____ TO _____

_____ _____

NAME (Please Print Clearly) DATE

_____

ADDRESS

_____ _____

SIGNATURE (If relative, please state relationship) DATE OF BIRTH