Oscar T. Ortiz, M.D. Ronald B. Villanueva, M.D. Francisco D. Cruz, M.D.
Ahmet S. Can, M.D. Leslie Taguba-Madrid, M.D.

REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby request that my records be released and sent to:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

I hereby request that my records be released from:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

Patient requesting transfer:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

Dates of treatment: _____

Patient's Date of Birth: _____

_____ _____

Patient's Signature Date